Certificate of Death

STATE OF IDAHO

State File No. 2701
Local Reg. No. 131
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JUL 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 210 G St.

3. NAME OF DECEASED (Type or Print): a. (First) OSCAR b. (Middle) c. (Last) GULBRANSEN

4. DATE OF DEATH (Month) (Day) (Year): June 21, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: Jan 23, 1901

9. AGE (In years last birthday): 67
IF UNDER 1 YR. Months: 4 Days: 28
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CO

10b. KIND OF BUSINESS OR INDUSTRY: U. P. Railroad

11. BIRTHPLACE (State or foreign country): Thatcher, Idaho

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Otto D. Gulbransen
BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Anna Marie Anderson
BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): War II

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: William E. Gulbransen
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia, acute. — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coagulase + staphylococcus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Myelogenous leukemia, Autoimmune hemolytic anemia — about 3 months

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1967 to June 1969, that I last saw the deceased alive on June 21, 1969, and that death occurred at 10:57 a.m., from the causes and on the date stated above.

23a. SIGNATURE: C.H. L. Bingham M.D. (Degree or title)
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem & Bur
24b. DATE: June 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Thatcher Cemetery
24d. LOCATION (City, town, or county) (State): Thatcher, Idaho

DATE REC'D BY LOCAL REG.: July 8-1969
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Leo A. Williams
LICENSE NO.: E.319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 3 1969

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2702
Local Reg. No. 223
Reg. Dist. No. 610

BIRTH NO.

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 JUL 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): s Idaho Falls
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Residence 1302 Shipp Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1302 Shipp Ave

3. NAME OF DECEASED (Type or Print)
a. (First): Laura
b. (Middle):
c. (Last): Mahoney

4. DATE OF DEATH: June 22, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: March 9, 1920

9. AGE (In years last birthday): 49
IF UNDER 1 YR. Months: 3 Days: 13
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pittsburg, Penna.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Stanley Kowaleski
BIRTHPLACE: Poland

14. MOTHER'S MAIDEN NAME: Katherine Zegacewski
BIRTHPLACE: Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 2

16. SOCIAL SECURITY NO.: 175-16-3262

17. INFORMANT'S OWN SIGNATURE: John W. Mahoney
ADDRESS: Idaho Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): C. V. A.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Arterio Sclerosis

INTERVAL BETWEEN ONSET AND DEATH: 1 week

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wendell L Nielsen (Degree or title) 3401
23b. ADDRESS: Idaho Falls, Ida
23c. DATE SIGNED: 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/26/69
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: July 8-1969
REGISTRAR'S SIGNATURE: Anna Rudges

25. EMBALMER: Bo A Williams
LICENSE NO.: E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 2703
Local Reg. No. 219
Reg. Dist. No. 610

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY: 21 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 120 West 20th Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 120 West 20th Street

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): F.
c. (Last): LEHMAN

4. DATE OF DEATH (Month) (Day) (Year): June 23,1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov.26,1913
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mtcemn 21
10b. KIND OF BUSINESS OR INDUSTRY: Idaho Nuclear
11. BIRTHPLACE (State or foreign country): Richardton,North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Lehman — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Rosina Fuchs — BIRTHPLACE: South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): W.W. II 4
16. SOCIAL SECURITY NO.: 566-07-7813
17. INFORMANT'S OWN SIGNATURE: Mrs Robert Lehman — ADDRESS: Idaho Falls,Idaho

4189

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS, BONNEVILLE, IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7-, 1965, *to* 6-23-, 1969, *that I last saw the deceased alive on* 6/12, 1969, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leland T. [illegible] 294
23b. ADDRESS: IDAHO FALLS, IDAHO 83401
23c. DATE SIGNED: 6/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/27/69
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls,Idaho

DATE REC'D BY LOCAL REG.: July 3-1969
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Jack A. Wood, Jr.
LICENSE NO.: 396

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WOOD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 2704
Local Reg. No. 224
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 JUL 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 101
a. STATE Idaho b. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1285 Orlin Drive

3. NAME OF DECEASED (Type or Print) a. (First) Juanita b. (Middle) Helen c. (Last) Olson
4. DATE OF DEATH (Month) (Day) (Year) June 23, 1969
5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Dec. 27, 1929
9. AGE (In years last birthday) 39 IF UNDER 1 YR. Months 5 Days 26 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wapello, Idaho
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Andrew Johnson BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Rose Moore BIRTHPLACE Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 3959
17. INFORMANT'S OWN SIGNATURE Irene B. Olson ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) aortic stenosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rheumatic heart disease 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 4, 19 69, *to* June 23, 19 69, *that I last saw the deceased alive on* June 22, 19 69, *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Byron T. Weeks (Degree or title) MD 10556 23b. ADDRESS 585 So. Boulevard, Idaho Falls 23c. DATE SIGNED 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/26/69
24c. NAME OF CEMETERY OR CREMATORY Fielding Memorial Park
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. July 8-1969
REGISTRAR'S SIGNATURE Anna Hedges
25. EMBALMER Leo A. Williams
LICENSE NO. E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

BIRTH NO. 69-5574

RECEIVED JUL 8 1969 Bureau of Vital Statistics

State File No. 2705
Local Reg. No. 220
Reg. Dist. No. 610

1. PLACE OF DEATH a. COUNTY Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, c. LENGTH OF STAY (If in hospital or place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Basalt,
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First) Matthew	b. (Middle) John	c. (Last) Lott	4. DATE OF DEATH (Month) June (Day) 25 (Year) 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH May 27 1969	9. AGE (In years last birthday) IF UNDER 1 YR. Months Days 29 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Babe 02	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Seth John Lott	BIRTHPLACE Idaho Falls, Idaho	14. MOTHER'S MAIDEN NAME Mary Ann Taylor,	BIRTHPLACE Franklin, Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. None	17. INFORMANT'S OWN SIGNATURE Seth J. Lott	ADDRESS Box 116 Basalt	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7514

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Immunition	days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Insufficient Small Bowel	birth
DUE TO (c)	Tegmial Atresia	"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 3 Jan	19b. MAJOR FINDINGS OF OPERATION Small Bowel atresia	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 days old, 19____, *to* death, 19____, *that I last saw the deceased alive on* 25 Jun, 1969, *and that death occurred at* 2:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 230 [signature]	(Degree or title) [illegible]	23b. ADDRESS 2065-175	23c. DATE SIGNED 30 Jun 69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-28-69	24c. NAME OF CEMETERY OR CREMATORY Basalt,	24d. LOCATION (City, town, or county) Shelley, R#1 (State) Idaho
DATE REC'D BY LOCAL REG. July 5 1969	REGISTRAR'S SIGNATURE Emma Bridges	25. EMBALMER [signature]	LICENSE NO. E 275

FIRM NAME: Maldin's

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2706
Local Reg. No. 216
Reg. Dist. No. 6/6

BIRTH NO.

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 3 yrs
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 7815 Wesley Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	Russell	Shade	June 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Jan. 20, 1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer 21	Highway Dept.	Huron, So. Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charley Shade	Pennsylvania	Ida Swansen	Morris, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes / WW II 4	473-07-9257	+ Hazel M. Shade	

4319

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 - 14 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-25-69, 19____, *to* 6-25-69, 19____, *that I last saw the deceased alive on* 6-25-69, 19____, *and that death occurred at* 5:20 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] /	IDAHO FALLS, IDAHO 83401	7/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial /	6-30-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 8 - 1969	[signature]	[signature]	E-397

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 16 1969

NOV 28 1973

APR 22 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2707
Local Reg. No. 237
Reg. Dist. No. 670

BIRTH NO. 69-5673

RECEIVED JUL 23 1969

1. PLACE OF DEATH
a. COUNTY Bonneville 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 36 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION LDS Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 48 b. COUNTY King 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bellview
d. STREET ADDRESS (If rural, give location) 14826 S.E. 38th

3. NAME OF DECEASED (Type or Print) a. (First) TRENNA b. (Middle) c. (Last) JENKINS
4. DATE OF DEATH (Month) (Day) (Year) June 26,1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH June 24,1969
9. AGE (In years last birthday) 0
IF UNDER 1 YR. Months Days 1½
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY Infant
11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Allen Dale Jenkins
BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Ann Rockwood
BIRTHPLACE Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 2 0
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Dale Jenkins ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7761

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hyaline Membrane — INTERVAL BETWEEN ONSET AND DEATH 36 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity — 36 hours
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Patent Ductus Arteriosus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 24 July, 1969, to 26 July, 1969, that I last saw the deceased alive on 26 July, 1969, and that death occurred at 11:55 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Idaho Falls Idaho
23c. DATE SIGNED 28 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/28/69
24c. NAME OF CEMETERY OR CREMATORY Ucon Cemetery
24d. LOCATION (City, town, or county) (State) Ucon, Idaho

DATE REC'D BY LOCAL REG. July 16-1969
REGISTRAR'S SIGNATURE Emma Burgess
25. EMBALMER Jack A. Wood Jr.
LICENSE NO. 396
FIRM NAME: WOOD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 16 1969 Bureau of Vital Statistics

State File No. 2708
Local Reg. No. 225
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GOOD SAMARITAN CONV. HOME 348

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO 13
b. COUNTY: BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): 222 E. 16th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FLOYD	F. (Doc)	MC CULLOUGH	June 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	wdpwed 2	15 Nov 1903	65	7 / 13	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carman for railroad 10	Union Pacific	Rigby, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Mc, Cullough	Ut	Kate Cole	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	4369	Jane D. Floyd	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
.m.		

22. *I hereby certify that I attended the deceased from* 11-6-67, 19____, *to* 6-28-69, 19 69, *that I last saw the deceased alive on* 6-20-69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
432 Milton T. Rees M.D.	Idaho Falls, Idaho	7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem & Bur 5	7/1/69	Pioneer Cemetery	Rigby, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10-69	Anna Rudger	Leo A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2709
Local Reg. No. 32-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED JUN 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN: Bonners Ferry
c. LENGTH OF STAY IN (this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Bench 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). 301
a. STATE: Idaho
b. COUNTY: Nez Perce 337
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 930 Burrell Avenue

3. NAME OF DECEASED (Type or Print): a. (First) ELMER; b. (Middle) JESS; c. (Last) ROUSE

4. DATE OF DEATH (Month) (Day) (Year): June 2, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: January 12, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: A griculture

11. BIRTHPLACE (State or foreign country): Shade Gap, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Harris O. Rouse
BIRTHPLACE: Pennsylvania

14. MOTHER'S MAIDEN NAME: Mattie Snyder
BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 518-12-4117-A

17. INFORMANT'S OWN SIGNATURE: Gareth E Rouse
ADDRESS: Longview Wash.

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 6 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE: C M. Callahan (Degree or title): Coroner 4
23b. ADDRESS: Bonners Ferry, Idaho
23c. DATE SIGNED: 6/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/9/69
24c. NAME OF CEMETERY OR CREMATORY: Powers Lake
24d. LOCATION (City, town, or county) (State): Powers Lake North Dakota

DATE REC'D BY LOCAL REG.: June 6, 1969
REGISTRAR'S SIGNATURE: Myrla Stone
25. EMBALMER: [signature]
LICENSE NO.: E-453
FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2710
Local Reg. No. 33-69
Reg. Dist. No. 100

RECEIVED JUN 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Porthill
LENGTH OF STAY (in this place): 500 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hgwy #95, 1 mi So. of Porthill 800

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Canada 52
b. COUNTY: Quebec 555
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: Laval West
d. STREET ADDRESS (If rural, give location): 3301 - 16th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RANDOLPH	BYRON EUGENE	NELSON	June 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married 1	April 3, 1945	24				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	West Coast Shows	Kirkland Lake, Ontario, Canada	Canada

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert E. Nelon	Phoenix, British Columbia	Mary L. Parker	Calgary, Ontario, Can.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2 8199		K. E. Nelson	Laval West Quebec, Canada

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Multiple Skull Fracture	Instant
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Fractured Neck and Back	Instant
DUE TO (c)	Multiple Internal Injuries	Instant
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	One Car Accident	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident 1	Highway #95 06	Porthill, Boundary County, Idaho 110

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
6/15/69 9:00 P. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	One Car Accident

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Callahan 583	Coroner 4	Bonners Ferry, Idaho	6/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	6/20/69	Grandview Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 19, 1969		Charles M. Nelson	E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2711
Local Reg. No. 24-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
JUL 7 1969

1. PLACE OF DEATH
a. COUNTY Boundary 110 315
b. CITY OR TOWN Bonners Ferry
c. LENGTH OF STAY (in this place) 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Porthill
d. STREET ADDRESS (If rural, give location) General Delivery

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	SAMUEL	EARL	SCHALLER	June 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	December 15, 1880	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Agriculture	Saguache, Colorado	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred Schaller	Switzerland	Elizabeth Smetton	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		519-05-1584	Stanley a Schaller	Umatilla, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	C.V.A.	2 Hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from MAY, 1969, to 24 June, 1969, that I last saw the deceased alive on 24 June, 1969, and that death occurred at 9A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edwards 153 MD	Bonners Ferry Ida	6/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/27/69	Copeland Cemetery	Copeland Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
			E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 9 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2712
Local Reg. No. 35-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED JUL 7 1969 STATE OF IDAHO
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN: Bonners Ferry
c. LENGTH OF STAY IN THIS PLACE: 1 mo 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Community Restorium

3. NAME OF DECEASED (Type or Print): a. (First) SHIRLEY b. (Middle) J. c. (Last) WOOD

4. DATE OF DEATH: (Month) June (Day) 25, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: July 19, 1886

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 64

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Mason City, Iowa

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Henry A. Wood — BIRTHPLACE: Tennessee

14. MOTHER'S MAIDEN NAME: Harriet L. Davis — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-40-6667A

17. INFORMANT'S OWN SIGNATURE: Mrs Helen Mellem — ADDRESS: Libby, Montana

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Ca of colon — 4 mo
with abdominal abscess — 2 mo

19a. DATE OF OPERATION: May 69

19b. MAJOR FINDINGS OF OPERATION: Ca colon

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1969 *to* June, 1969, *that I last saw the deceased alive on* 6/25, 69, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD — **23b. ADDRESS**: Bonners Ferry — **23c. DATE SIGNED**: 6/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 6/30/69 — **24c. NAME OF CEMETERY OR CREMATORY**: I.O.O.F. Cemetery — **24d. LOCATION** (City, town, or county) (State): Porthill Idaho

DATE REC'D BY LOCAL REG. — REGISTRAR'S SIGNATURE

25. EMBALMER: [signature] — LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2713
Local Reg. No. 3069
Reg. Dist. No. 100

RECEIVED JUL 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boundary 510
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 10 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print) a. (First) CHRISTEN b. (Middle) PEDER c. (Last) KIILSGAARD

4. DATE OF DEATH (Month) (Day) (Year) June 30, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Jan. 12, 1886

9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Folbey, Denmark

12. CITIZEN OF WHAT COUNTRY? Nat. US

13. FATHER'S NAME Hans M. Kiilsgaard BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Henrietta Hansen BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 2 (If yes, give war or dates of service) --

16. SOCIAL SECURITY NO. 533-14-2461

17. INFORMANT'S OWN SIGNATURE Irene O. Koch ADDRESS Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion 4189 — INTERVAL BETWEEN ONSET AND DEATH 20 minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from _____, 19 60, to 6/30, 19 69, that I last saw the deceased alive on 6/30, 19 69, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD 153 — 23b. ADDRESS Bonners Ferry Idaho — 23c. DATE SIGNED 7/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE 7/3/69 — 24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery — 24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. July 8, 1969 — REGISTRAR'S SIGNATURE

25. EMBALMER — LICENSE NO. E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 7 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2714
Local Reg. No. 12
Reg. Dist. No. 6-70

RECEIVED JUN 13 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Arco
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3 miles E. Hiway 20-26

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Canada 52
b. COUNTY: B. C. 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): North Vancouver
d. STREET ADDRESS (If rural, give location): 204 East 4th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	WILLIAM	EDWIN	TAYLOR

4. DATE OF DEATH (Month) (Day) (Year): June 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Divorced 4	April 25, 1924	45				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown 00		North Bay, Ontario, Canada	Canada

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clarence Taylor	Canada	Meron Lidkea	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 3	8199		Mother Information from	Arco, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable fracture of cervical vertebra — INTERVAL BETWEEN ONSET AND DEATH: 10 mins.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Head injuries
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident 1	Hiway 06	Arco 3	Butte 120	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
June 2, 1969 4p m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Auto accident

22. *I hereby certify that I attended the deceased from* Attended as Coroner Only, 19___, *to* ____, 19___, *that I last saw the deceased alive on* ____, 19___, *and that death occurred at* 4:12p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. H. Marvel 533	Butte Co. Coroner 4	Arco, Idaho	6-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-5-69	Hillcrest Cemetery	Arco, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 11-1969	Betty J. Marvel	C. H. Marvel	E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 23 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 29 1970

AUG 11 1970

NOV 29 1971

JUL 26 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2715
Local Reg. No. 73
Reg. Dist. No. 670

RECEIVED JUL 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Butte 120 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
LENGTH OF STAY (in this place): 1 hr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Butte 120
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
d. STREET ADDRESS (If rural, give location): Thelma Ave.

3. NAME OF DECEASED (Type or Print): a. (First) FRED; b. (Middle) M.; c. (Last) KINSFATHER

4. DATE OF DEATH: (Month) (Day) (Year) June 29, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: March 24, 1887

9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Cattle Ranching

11. BIRTHPLACE (State or foreign country): Crookston, No. Dakota

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Fred M. Kinsfather
BIRTHPLACE: Austria

14. MOTHER'S MAIDEN NAME: Unobtainable
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 489-30-6965

17. INFORMANT'S OWN SIGNATURE: F. L. Kinsfather
ADDRESS: Arco, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adens Carcinoma of Colon — 2yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Anemia

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan 1969, *to* June 29, 1969, *that I last saw the deceased alive on* 6-29, 1969, *and that death occurred at* 11:28 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. Baker MD (Degree or title)
23b. ADDRESS: Arco, Ida
23c. DATE SIGNED: 7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. Burial
24b. DATE: 7-1-69
24c. NAME OF CEMETERY OR CREMATORY: Mound Grove
24d. LOCATION (City, town, or county) (State): Independence, Mo.

DATE REC'D BY LOCAL REG.: July 8. 1969
REGISTRAR'S SIGNATURE: Betty J. Marvel
25. EMBALMER: C. H. Marvel
LICENSE NO.: E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service
Form PH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2716
Local Reg. No. ____
Reg. Dist. No. ____

BIRTH NO.

RECEIVED JUN 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Camas 13
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield
c. LENGTH OF STAY (In this place): 5 or 6
d. FULL NAME OF HOSPITAL OR INSTITUTION: Residence-1 West & 2 No. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Camas 130
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield
d. STREET ADDRESS (If rural, give location): 1-W. & 2 No. of Soldier

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Milo	Warren	Baker	June 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Nov. 1, 1899	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer-Rancher Of	Agriculture	Dunning, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Warren J. Baker	Kentucky	Christine Jensen	Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-40-9904	X Joanne D Baker	Fairfield, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	188X	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cancer of Urinary Bladder	3 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jun 69	Cancer of Urinary Bladder	Yes ☐ No ☒ XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1967 19__, to 16 June 19 69, *that I last saw the deceased alive on* 16 June 19 69, *and that death occurred at* 6:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marion J Kerns 379	MD	Fairfield Ida	19 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-19-1969	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June-19-1969	Estelle Vaught	Fred J. Nelson	E-504

FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2717
Local Reg. No. 317
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JUL 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 14
b. CITY OR TOWN: Caldwell
c. LENGTH OF STAY (in this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Snohomish 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Everett
d. STREET ADDRESS (If rural, give location): 1611 Center Road

3. NAME OF DECEASED (Type or Print): a. (First) Harold b. (Middle) Vonieda c. (Last) Wesseling

4. DATE OF DEATH: (Month) May (Day) 19 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 27, 1911

9. AGE (In years last birthday): 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Market Owner 22

10b. KIND OF BUSINESS OR INDUSTRY: Food

11. BIRTHPLACE (State or foreign country): Harrison, South Dakota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry J. Wesseling
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Elvira Harris
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 3 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Lena Wesseling
ADDRESS: Everett, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Miliary tuberculosis granuloma of the liver, spleen and possibly brain

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Undetermined organism

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Aspiration pneumonitis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 4/16/69

19b. MAJOR FINDINGS OF OPERATION: Miliary lesions of liver & spleen

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 2 1969, *to* May 18, 1969, *that I last saw the deceased alive on* May 18, 1969, *and that death occurred at* 6:50A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Charles E. Reed (Degree or title): M.D.

23b. ADDRESS: 222 E. Elm Caldwell Idaho

23c. DATE SIGNED: 7/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: May 22, 1969

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: July 10, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: John F. Alsip

LICENSE NO.: E361

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 1 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2718
Local Reg. No. 301
Reg. Dist. No. 360

RECEIVED
JUN 26 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 140
b. CITY OR TOWN Middleton
(If outside corporate limits, write RURAL and give township) 122
LENGTH OF STAY (in this place) 22 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) City, Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Middleton
d. STREET ADDRESS (If rural, give location) City, P.O. Box 42

3. NAME OF DECEASED (Type or Print)
a. (First) Willard
b. (Middle) Elijah
c. (Last) Cox

4. DATE OF DEATH (Month) (Day) (Year) May 24, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 2, 1896
9. AGE (In years last birthday) 73
IF UNDER 1 YEAR Months 0 Days 22
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 54 Real Estate Broker
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Portland, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE Charles Cox-Marshalltown, Iowa
14. MOTHER'S MAIDEN NAME BIRTHPLACE Edith Jones, Erie, Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI 3
16. SOCIAL SECURITY NO. 540-16-4829
17. INFORMANT'S OWN SIGNATURE ADDRESS X Alice M Cox

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14-68, 19___, *to* 5-24-69, 19___, *that I last saw the deceased alive on* 12-2-68, 19___, *and that death occurred at* ? *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) J. C. Miller M.D.
23b. ADDRESS 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED 6-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 5-28-1969
24c. NAME OF CEMETERY OR CREMATORY Middleton Cemetery
24d. LOCATION (City, town, or county) Middleton, Idaho (State)

DATE REC'D BY LOCAL REG. June 25, 1969
REGISTRAR'S SIGNATURE Mrs. Martin Walmsley
25. EMBALMER Leonard C. Flahiff
LICENSE NO. E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2719
Local Reg. No. 305
Reg. Dist. No. 360

RECEIVED JUL 2 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 355
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jordan Valley
d. STREET ADDRESS (If rural, give location): Box 297

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Maria	J.	Corta	May 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	6-13-1877	91	11	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Self	Ispastar Vizcaya, Spain	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Miguel Ocamica	Spain	Aguada Zaracondegui	Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	543-44-5567	X Joe Corta	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary occlusion	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Myocardial Infarction	Sudde
DUE TO (c)	old age	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerotic Heart Disease	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1954, 19__, *to* 1969, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] MD	Nampa	6/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-3-1969	Jordan Valley Cemetery	Jordan Valley Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 1, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2720
Local Reg. No. 290
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JUN 12 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (IDCA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing
d. STREET ADDRESS (If rural, give location): Box 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Vera	Leona	Hamilton	June 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Nov. 16, 1901	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Algiers, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Stephenson	Algiers, Indiana	Emma Oberst	Jasper, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
3		3480	L A Hamilton	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Amyotrophic Lateral Sclerosis~~ — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ~~E~~ Bulbar Involvement
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12/23/ *, 19* 65 *to* 6/1/ *, 19* 69, *that I last saw the deceased alive on* 6/1/ *, 19* 69 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
454 Joe Saltzer MD	Nampa	6/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 4, 1969	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 11, 1969	Mrs. Martina Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 27 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2721
Local Reg. No. 270
Reg. Dist. No. 360

Certificate of Death

RECEIVED
JUN 6 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WILDER
c. LENGTH OF [illegible]: 800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOME- Second Street East Wilder

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Second Street East

3. NAME OF DECEASED (Type or Print)
a. (First): VICTOR
b. (Middle): M.
c. (Last): KROH

4. DATE OF DEATH (Month) (Day) (Year): June 1, 1, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 1, 1909
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Furniture Store Owner
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Kansas City Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Kroh — BIRTHPLACE: Russia 22
14. MOTHER'S MAIDEN NAME: Anna E. Foltz — BIRTHPLACE: Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): W.W.II 4
16. SOCIAL SECURITY NO.: 519 07 6942
17. INFORMANT'S OWN SIGNATURE: Belva Doris Kroh — ADDRESS: Wilder, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Occlusion.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection & Autopsy, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* Found 7:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche M.D. Coroner 583 4
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 6-3-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: June 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: June 5, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487
FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 24 1984

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2722
Local Reg. No. 278
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JUN 10 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (RCA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 5

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ollie	Dell	Whitmire	June 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Dec. 15, 1905	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Oark, Arkansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: E. L. Yates — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Maude Acord — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 3-385-8401
17. INFORMANT'S OWN SIGNATURE: O W Whitmire — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer lung — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*: Pulmonary emphysema

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Lung, bronchi Jan. 69 - Malignancy	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (Inside or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1969, *to* June 1, 1969 *that I last saw the deceased alive on* 6-1-, 1969, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] MM		Caldwell Ida	6-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 4, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 9, 1969	Mrs. Martina Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2723
Local Reg. No. 277
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUN 9 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (IDCA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Huston
d. STREET ADDRESS (If rural, give location): Box 8

3. NAME OF DECEASED (Type or Print): a. (First) Arthur; b. (Middle); c. (Last) Garza

4. DATE OF DEATH (Month) (Day) (Year): June 2, 1969

5. SEX: Male

6. COLOR OR RACE: Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 14, 1950

9. AGE (In years last birthday): 19
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Meyers, Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ramon Garza
BIRTHPLACE: Texas

14. MOTHER'S MAIDEN NAME: Maria Rios
BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): O
(If yes, give war or dates of service): O

16. SOCIAL SECURITY NO.: 455-84-7208

17. INFORMANT'S OWN SIGNATURE: × Ramon Garza
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Injuries 8769

INTERVAL BETWEEN ONSET AND DEATH: A few

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Caldwell 3 Canyon Idaho 141

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 2 1969 12:20 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Car left road and rolled over

22. *I hereby certify that I attended the deceased from* June 2, 1969, *to* Only, 19___, *that I last saw the deceased alive on* June 2, 1969, *and that death occurred at* 4:29 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD

23b. ADDRESS: Caldwell Ida

23c. DATE SIGNED: 6-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: June 3, 1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: June 6, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: James R. Dahan

LICENSE NO.: E-485

FIRM NAME: Dahan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2724
Local Reg. No. 286
Reg. Dist. No. 360

BIRTH NO.

JUN 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place): 2 wks. 314
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 230
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print)
a. (First): Velma
b. (Middle): Leona
c. (Last): Limbaugh

4. DATE OF DEATH (Month) (Day) (Year): June 2, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Jan. 15, 1908
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months 5, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Puyallup, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Woodson Jones — BIRTHPLACE: London, Kentucky
14. MOTHER'S MAIDEN NAME: Clara Alice Ray — BIRTHPLACE: St. Clair, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 3 — (If yes, give war or dates of service): 486X
16. SOCIAL SECURITY NO.: 519 46 0813
17. INFORMANT'S OWN SIGNATURE: X O.E. Limbaugh — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Status post-operative for dorsal (abdominal) eventyon

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-1-69, 19__, *to* 6-2-69, 19__, *that I last saw the deceased alive on* 6-2-69, 19__, *and that death occurred at* 12:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 250 [signature]
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 6-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: June 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: June 11, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 9 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2725
Local Reg. No. 293
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUN 17 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 14 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale Rural
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Eufemia
b. (Middle): P.
c. (Last): Macias

4. DATE OF DEATH (Month) (Day) (Year): June 2 1969

5. SEX: Female
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 15, 1912
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months 2, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Wisaches Altos, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Florentino Patino — BIRTHPLACE: Villa Nueva, Texas
14. MOTHER'S MAIDEN NAME: Julia Garza — BIRTHPLACE: Rio Grande, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No 2
16. SOCIAL SECURITY NO.: 456-14-2200
17. INFORMANT'S OWN SIGNATURE: Yolanda DeLeon — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer Cervix — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* June 2, 1969, *that I last saw the deceased alive on* June 2, 1969, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 437 Mr
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: June 12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Marsing-Homedale
24d. LOCATION (City, town, or county) (State): near Homedale, Idaho

DATE REC'D BY LOCAL REG.: June 13, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2726
Local Reg. No. 284
Reg. Dist. No. 360

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 14 JUN 12 1969 302
b. CITY OR TOWN Caldwell
c. LENGTH OF STAY (in this place) 2dy
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Oregon 38
b. COUNTY Malheur 355
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nyssa
d. STREET ADDRESS (If rural, give location) 100 Chestnut Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Clarence b. (Middle) Alvis c. (Last) Reece
4. DATE OF DEATH (Month) (Day) (Year) 6-2-1969
5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 8-1-1894
9. AGE (In years last birthday) 74 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John F Reece BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Stella E Buck BIRTHPLACE Missouri
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 542-14-0116
17. INFORMANT'S OWN SIGNATURE Edith Reece ADDRESS 100 Chestnut Nyssa Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pernicious anemia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION BOH
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-20, 1969, *to* 6-2-, 1969, *that I last saw the deceased alive on* 6-2, 1969, *and that death occurred at* 9:50 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS 1920 Ellis Ave
23c. DATE SIGNED 6-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-7-1969
24c. NAME OF CEMETERY OR CREMATORY Nyssa
24d. LOCATION (City, town, or county) (State) Nyssa Oregon

DATE REC'D BY LOCAL REG. June 11, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. FUNERAL DIRECTOR
ADDRESS Nyssa Oregon

Federal Security Agency
United States Public Health Service
Form DPH-46021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2727
Local Reg. No. 280
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUN 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY CANYON 14 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
LENGTH OF STAY (in this place) 3 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY CANYON 14
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 6 OGDEN

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CHARLES	H.	BURNS	JUNE 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED 3	JULY 23, 1891	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED BROKER 30	PRODUCE	LONGMONT, COLORADO	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
THOMAS BURNS	CANADA	MATTIE ASH	INDINIA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 0	519 30 0289A	x C. Robert Burns	NAMPA, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4367

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) St. Occ — INTERVAL BETWEEN ONSET AND DEATH 10 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Skull Fracture & Brain Contusion — 6 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES XX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1/24/ *, 19*69*, to* 6/4/ *, 19*69*, that I last saw the deceased alive on* 6/4/ *, 19*69*, and that death occurred at* 2:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward W Brown MD	NAMPA, IDAHO	6/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	6-7-1969	CLOVERDALE MEMORIAL PARK	BOISE, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 10, 1969	Mrs. Martin Walmsley	M. B. Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 6 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2728
Local Reg. No. 281
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUN 12 1969 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 14 — c. LENGTH OF RESIDENCE (in this place): 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell — 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho — b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Box 487

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Erineo	Jose	Mora Jr.	June	4	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Mexican	Never Married	2-27-1966	3	3	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child 02	None	Kilman, Arizona	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Erineo J. Mora Sr.	Edenburg, Texas	Margariete Cruz	Mission, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	8	None	X Erineo Jos Mora	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Down's Syndrome — 3yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2 June, 1969, *to* 4 June, 1969, *that I last saw the deceased alive on* 4 June, 1969, *and that death occurred at* 5:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] Anderson M.D.	Caldwell	6 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 5, 69	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 11, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2729
Local Reg. No. 287
Reg. Dist. No. 360

RECEIVED JUN 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN: Nampa
LENGTH OF STAY (in this place): 600
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Upper Lake Lowell Dam 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Box 1009

3. NAME OF DECEASED (Type or Print): a. (First) Ray; b. (Middle) Vernon; c. (Last) Worley

4. DATE OF DEATH: (Month) (Day) (Year): June 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Sept. 18, 1908	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Land Leverler C6
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Reamsville, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Perry Albert Worley — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Eva Sarah Rouse — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 512-12-1763
17. INFORMANT'S OWN SIGNATURE: X Vesta Worley — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Broken Neck — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fell into Lake

8837

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Lake Lowell 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Canyon 140 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 6-4-69 4:P m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Apparently Fell off a Wall into Lake

22. *I hereby certify that I attended the deceased from* Inspection duty, 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesch M.D. 583 Coroner 4
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 6-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: June 11, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: B. Shepherd
LICENSE NO.: 473
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2730
Local Reg. No. 291
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUN 17 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 328 1st No Ext.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Oliver	Francis	Clemens	June 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	April 1, 1883	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dr		Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Beech Clemens	Unknown	Amanda Raines	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 3	0	542-07-9512	X R C Clemens	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Adenocarcinoma - Primary sub undetermined with metastases — 2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6/4/ , 19 69, *to* 6/5/ , 19 69 *that I last saw the deceased alive on* 6/5/ , 19 69 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	619 So. Canyon, Nampa, Idaho	6/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	June 7, 1969	Woodburn Cemetery	Woodburn, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 13, 1969	Mrs. Martina Walmsley	[signature]	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 16 1969

OCT 23 1980

JAN 31 1986

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2731
Local Reg. No. 289
Reg. Dist. No. 360

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (IDCA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 14/JUN 12 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 360
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. View Terrace Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Oscar	Brian	Van Natta	June 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	Oct. 11, 1895	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
88		Allen Co., Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Henry Van Atta	Wisconsin	Nellie E. Miller	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	1579	549-16-0187A	X Ollie Hanson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Sacrum — INTERVAL BETWEEN ONSET AND DEATH: 4 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 11:40 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. L. Sorensen M.D.	Caldwell Idaho	10 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 9, 1969	New Plymouth Cemetery	New Plymouth, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 11, 1969	Mrs. Martina Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 27 1969 Bureau of Vital Statistics

State File No. 2732
Local Reg. No. 302
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 415 Fern

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NELLIE	ISABELL	DYER	June 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	Feb. 22, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Westboro, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Phillips	Ill.	Lena Ewoldsen	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0 4123	518-36-0520	Thelma D. Nelson	Oak Harbor Wash

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) A S H D. with C.H.F. — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2/22/ , 19 67 *to* 6/6/ , 19 69 , *that I last saw the deceased alive on* 6/6/ , 19 69 , *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard C. Jaeger M.D.	619 So. Canyon, Nampa, Idaho	6-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/9/69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 26, 1969	Mrs. Martin Walmsley	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 3 1969

OCT 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUN 17 1969 Bureau of Vital Statistics

State File No. 2733
Local Reg. No. 292
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell c. LENGTH OF STAY (If in hospital): 23 Days 201	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051	d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)	a. (First) LEON	b. (Middle) J.	c. (Last) ELLIOTT	4. DATE OF DEATH (Month) (Day) (Year)	June 8, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: June 25, 1884	9. AGE (In years last birthday): 84	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stockman 04	10b. KIND OF BUSINESS OR INDUSTRY: ranching	11. BIRTHPLACE (State or foreign country): Eugene, Oregon	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Henderson Elliott	BIRTHPLACE: Illinois	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Illinois		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 3 (If yes, give war or dates of service) 0--	16. SOCIAL SECURITY NO.: 550-34-1705	17. INFORMANT'S OWN SIGNATURE: Hazel Elliott	ADDRESS: Rt 1 Boise Ida		

18. CAUSE OF DEATH — 342X

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Parkinsonism	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	left [illegible] artery	month
DUE TO (c)	insufficiency	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	myocardial ischemia all due to arteriosclerosis	

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-16, 1969, *to* 6-8, 1969, *that I last saw the deceased alive on* 6-18, 1969, *and that death occurred at* 3:40 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature]	(Degree or title)	23b. ADDRESS: Caldwell Ida	23c. DATE SIGNED: 6-10-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 6-10-69	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: June 13, 1969	REGISTRAR'S SIGNATURE: Mrs Martina Walmsley	25. EMBALMER: [signature]	LICENSE NO.: E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2734
Local Reg. No. 296
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUN 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: CANYON 14
b. CITY OR TOWN: NAMPA
c. LENGTH OF STAY IN (this place): 35YRS. 135
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 614 18th AVE. NORTH

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 614 18th AVE. NORTH

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DAISY	BELLE	MATTOX	JUNE 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED 3	FEB. 18, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE 01	AT HOME	BERWYN, NEBRASKA	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JACOB CASE	NEBRASKA	HARRIETT PERKINS	NEBRASKA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 2	0 4100	518-26-9280	William J Mattox	NAMPA, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 Min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 19 69 *to* June 19 69, *that I last saw the deceased alive on* June 19 69, *and that death occurred at* 3:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
322 [signature] MD	NAMPA, IDAHO	6/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	JUNE 12, 1969	KOHLERLAWN CEMETERY	NAMPA, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 16, 1969	Mrs. Martina Walmsley	M B Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 2 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

In Reserve

Certificate of Death

RECEIVED JUN 12 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2735
Local Reg. No. 285
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma Rural
c. LENGTH OF STAY (in this place): 10yr 110
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RFD 2 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Parma
d. STREET ADDRESS (If rural, give location): RFD 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Kyle	Pace	Nielsen	6-8-1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Never Married	1-22-1959	10				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	School	Nyssa Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Melvin R Nielsen	Idaho	Shirle Pace	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	9229	None	x Melvin R. Nielsen	RFD 2 Parma Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound abdomen.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Farm 31	Near Parma 13 Canyon 140 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
6-8-69 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Gun went off. Unexpectedly.

22. *I hereby certify that I attended the deceased from* Autopsy only, 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wenske MD 583 Coroner 4	Nampa Idaho	6-10-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-11-1969	Parma Cemetery	Parma Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
June 11, 1969	Mrs. Martina Walmsley	[illegible]	Nyssa Oregon

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

JUL 2 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2736
Local Reg. No. 297
Reg. Dist. No. 360

RECEIVED JUN 18 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 080
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1509 Oregon

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Paul	C.	Stewart	June 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Sept. 4, 1893	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ranch Developer & Cattleman 4		St. Charles, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jim Stewart	Illinois	Salina Craven	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	War I	541-44-5977A	Ruth S. Stewart	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardiac Arrythmia	0
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary occlusion	6 mo
DUE TO (c)	Arteriosclerotic C.V.D.	6 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes, prostatitis	1 yr.

4123

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1 Nov, 1965, *to* 9 June, 1965, *that I last saw the deceased alive on* 9 June, 1965, *and that death occurred at* 7:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
473 L. Simpson M.D.	Caldwell	12 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Entombment 4	June 12, 1969	Hillcrest Memorial Mausoleum	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 17, 1969	Mrs. Martina Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 20 1969

JUL 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2737
Local Reg. No. 303
Reg. Dist. No. 360

RECEIVED JUN 27 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142 10k
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 6 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Nursing Home 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Midland Boulevard

3. NAME OF DECEASED (Type or Print)
a. (First): Emma
b. (Middle):
c. (Last): Lynch

4. DATE OF DEATH: June 10 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Jan. 6, 1877

9. AGE (In years last birthday): 92
IF UNDER 1 YEAR Months: 5 Days: 4
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeping 01

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): El Paso, Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Lynch
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Mary Hayes
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 3 8

16. SOCIAL SECURITY NO.: 519-56-2047

17. INFORMANT'S OWN SIGNATURE: Leonard C. Flahiff
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a): Pneumonia
INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c): Old Age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1 June 69 *to* 10 June 69, *that I last saw the deceased alive on* 10 June 69, *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): 3332
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 24 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 13, 69
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: June 26, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER:
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUL 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2738
Local Reg. No. 295
Reg. Dist. No. 360

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: CANYON 145 — JUN 17 1969 — 208
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY IN (this place): 8 MONTHS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PARK VIEW MANOR 396

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): *********

3. NAME OF DECEASED (Type or Print): a. (First) AXEL — b. (Middle) R. — c. (Last) NELSON

4. DATE OF DEATH (Month) (Day) (Year): JUNE 10, 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): NEVER MARRIED

8. DATE OF BIRTH: AUG. 18, 1889

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. LABOR

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): SALT LAKE CITY, UTAH

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CARL P. NELSON — BIRTHPLACE: SWEDEN

14. MOTHER'S MAIDEN NAME: CHRISTINA JOHNSON — BIRTHPLACE: SWEDEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 542 10 1959A

17. INFORMANT'S OWN SIGNATURE: Donald S. Weber — ADDRESS: NAMPA, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO (b)~~
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 15, 19 69, *to* 10 June, 19 69, *that I last saw the deceased alive on* 9 June, 19 69, *and that death occurred at* 5:45P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Benjamin Smith M.D. — **23b. ADDRESS**: NAMPA, IDAHO — **23c. DATE SIGNED**: 6-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — **24b. DATE**: 6-13-69 — **24c. NAME OF CEMETERY OR CREMATORY**: KOHLERLAWN CEMETERY — **24d. LOCATION** (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: June 16, 1969 — **REGISTRAR'S SIGNATURE**: Mrs. Martina Walmsley

25. EMBALMER: R. B. Shepherd — **LICENSE NO.**: 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2739
Local Reg. No. 300
Reg. Dist. No. 360

RECEIVED JUN 25 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (in this place) 19 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho State School & Hospital 052

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Box 594

3. NAME OF DECEASED (Type or Print) a. (First) Lonny b. (Middle) Dean c. (Last) Wells

4. DATE OF DEATH (Month) (Day) (Year) June 11, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH May 14, 1968
9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 68
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Roy Dean Wells BIRTHPLACE Nampa, Idaho
14. MOTHER'S MAIDEN NAME Judy Alverda Foreman BIRTHPLACE Nampa, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) 2 0
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Wilma Keyser ADDRESS Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cystic Encephalopathy — INTERVAL BETWEEN ONSET AND DEATH birth

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

7439

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-23, 1969, *to* 6-11, 1969, *that I last saw the deceased alive on* 6-11, 1969, *and that death occurred at* 5:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Box 47 Nampa
23c. DATE SIGNED Jun 30 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE JUNE 16, 1969
24c. NAME OF CEMETERY OR CREMATORY KOHLER LAWN CEMETERY
24d. LOCATION (City, town, or county) NAMPA, CANYON, (State) IDAHO

DATE REC'D BY LOCAL REG. June 24, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER M B Shepherd
LICENSE NO. E-473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2740
Local Reg. No. 298
Reg. Dist. No. 360

Certificate of Death

RECEIVED
JUN 23 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place): 5das.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma, Idaho
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)
a. (First): BERYL
b. (Middle): E
c. (Last): WISBEY

4. DATE OF DEATH (Month) 6 (Day) 13 (Year) 69

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 19, 1899
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR Months / Days: 10 24 — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Bangar So. Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Albano — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): No 0
16. SOCIAL SECURITY NO.: 519-46-9270
17. INFORMANT'S OWN SIGNATURE: X Rachel L Campbell — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer breast — INTERVAL BETWEEN ONSET AND DEATH: 5yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1964, *to* June, 1969, *that I last saw the deceased alive on* June 13, 1969, *and that death occurred at* 707 pm. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Karl E Ryder M 237
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 6/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/17/69
24c. NAME OF CEMETERY OR CREMATORY: Roswell
24d. LOCATION (City, town, or county) (State): Roswell, Idaho

DATE REC'D BY LOCAL REG.: June 20, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Lucy M. Flahiff — LICENSE NO. E393
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2741
Local Reg. No. 299
Reg. Dist. No. 360

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141 JUN 25 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): L.
c. (Last): Crookham, Sr.

4. DATE OF DEATH (Month) (Day) (Year): June 18, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 3, 1873
9. AGE (In years last birthday): 96 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pioneer Seed Producer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): High Bank, Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Horrace Crookham — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Mary Ann Montgomery — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-54-0775 JI
17. INFORMANT'S OWN SIGNATURE: Frank E. Crookham — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

885X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Fracture of the right femoral neck — 1 Mo.
DUE TO (c) advanced age

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX **SUICIDE** **HOMICIDE** (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) (STATE): Caldwell, Canyon, Idaho 140

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 5-22-69 a m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Stumbled and fell in his apartment

22. *I hereby certify that I attended the deceased from* May 22, 1969, *to* June 18, 1969, *that I last saw the deceased alive on* June 17, 1969, *and that death occurred at* 3 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Charles E. Kimrick 280 (Degree or title): MD 1
23b. ADDRESS: 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED: 6-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: June 24, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard D. Brust — LICENSE NO. E-500

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2742
Local Reg. No. 307
Reg. Dist. No. 360

RECEIVED JUL 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (in this place) 6 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1223 McKinney Lane

3. NAME OF DECEASED (Type or Print) a. (First) C L O I S b. (Middle) W A R N E R c. (Last) O W E N S

4. DATE OF DEATH (Month) (Day) (Year) June 18, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 15, 1898
9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Antimony, Garfield, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Mortimer Wallace BIRTHPLACE Kanosh, Utah
14. MOTHER'S MAIDEN NAME Margaret Elzira Frost BIRTHPLACE Spring City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 538
17. INFORMANT'S OWN SIGNATURE Glen E Owens ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH 2 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 5 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/18, 19 61 to June 18, 19 69, that I last saw the deceased alive on June 18, 19 69, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Arnold Brown MD
23b. ADDRESS 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED 6/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-21-1969
24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery
24d. LOCATION (City, town, or county) Boise Ada (State) Idaho

DATE REC'D BY LOCAL REG. July 3, 1969
REGISTRAR'S SIGNATURE Mrs. Martines Walmsley
25. EMBALMER Eldon T. Pearson LICENSE NO. E-512
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2743
Local Reg. No. 304
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUN 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 143
b. CITY OR TOWN Nampa
c. LENGTH OF STAY (In this place) 2 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 056

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 143
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 416-19 Avenue South

3. NAME OF DECEASED (Type or Print) a. (First) RALPH b. (Middle) IRWIN c. (Last) STEWART

4. DATE OF DEATH (Month) (Day) (Year) June 19, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH April 19, 1898

9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder 21

10b. KIND OF BUSINESS OR INDUSTRY Govt. Welding

11. BIRTHPLACE (State or foreign country) Prineville, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James E. Stewart BIRTHPLACE Virginia

14. MOTHER'S MAIDEN NAME Mary Workman BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 12-9009

17. INFORMANT'S OWN SIGNATURE * Bernice Stewart ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Stomach

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) with Metastasis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1968, *to* 19 June, 1969, *that I last saw the deceased alive on* 19 June, 1969, *and that death occurred at* 1:07 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE 328 (Degree or title)

23b. ADDRESS Nampa Idaho

23c. DATE SIGNED 25 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 23, 2969

24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State) Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG. June 27, 1969

REGISTRAR'S SIGNATURE Mrs Martina Walmsley

25. EMBALMER Jerry S Krouse

LICENSE NO. E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2744
Local Reg. No. 309
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon — 142 — JUL 7 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 13 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital — 053

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls — 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 270 Jefferson Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Linda	Diane	Whitten	June 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married	3-29-55	14				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 00	None	Twin Falls, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Herbert Whitten	California	Carol Ann Hekelar	California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 0	3439	Wilma Keyser	Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cachexia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Palsy.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-4, 19 55, *to* 6-20-69, 19___, *that I last saw the deceased alive on* 6-20, 1969, *and that death occurred at* 11:55P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
560 Henry C. Wesche M.D.	Nampa Idaho	6-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	6/20/69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 3, 1969	Mrs. Martina Walmsley	Richard W. Mesenbrink	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2745
Local Reg. No. 330
Reg. Dist. No. 360

RECEIVED JUL 18 1969

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 300 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. View Terrace Nursing Home 360

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell -Rural
d. STREET ADDRESS (If rural, give location): R# 1

3. NAME OF DECEASED (Type or Print)
a. (First): EVA
b. (Middle):
c. (Last): GRAHAM

4. DATE OF DEATH (Month) (Day) (Year): June 24, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 21, 1881
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Stoddard County, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas B. Proffer — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Virginia Reed — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-58-9782
17. INFORMANT'S OWN SIGNATURE: Elmer Graham — ADDRESS: Caldwell, Ida.

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-7-69, 19__, *to* 6-24-69, 19__, *that I last saw the deceased alive on* 6-11-69, 19__, *and that death occurred at* 2:40P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 250 [signature]
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/27/69
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: July 17, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Jerry S. Krouse
LICENSE NO.: E-447

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 16 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2746
Local Reg. No. 327
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 088
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma
d. STREET ADDRESS (If rural, give location): 211-3rd

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Evelyn	H.	Hoover	June 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	Oct. 6, 1887	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
08		Lexington, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Hooper	Unknown	Mary Alice Embree	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	518-05-7833B	[signature]	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3740

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral stenosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rheumatic Heart Disease — 50 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-12-55, 19___, *to* 6-25-69, 19___, *that I last saw the deceased alive on* 6-25-69, 19___, *and that death occurred at* 4:15P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	222 East Elm, Caldwell, Idaho	7-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 30, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 15, 1969	Mrs. Martina Walmsley	[signature]	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2747
Local Reg. No. 306
Reg. Dist. No. 360

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 JUL 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Grace
b. (Middle): H.
c. (Last): McShane

4. DATE OF DEATH (Month) (Day) (Year): June 25, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 26, 1883
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cascade, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: A. T. Swope — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Martha McCumber — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 0 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 541-24-6365Ji
17. INFORMANT'S OWN SIGNATURE: Helen L. Gibson — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: previous CVA

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from June 23, 1969, to June 25, 1969, that I last saw the deceased alive on June 25, 1969, and that death occurred at 7:30 A m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): 166
23b. ADDRESS: Caldwell, Ida
23c. DATE SIGNED: 6-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Weiser Cemetery
24d. LOCATION (City, town, or county) (State): Weiser, Idaho

DATE REC'D BY LOCAL REG.: July 1, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: James R. Dakan
LICENSE NO.: E-485

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2748
Local Reg. No. 321
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JUL 11 1969
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 309 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
d. STREET ADDRESS (If rural, give location) Route 6

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Harry	W.	Speer	June 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 15, 1898	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Livestock Dealer 07	Cattle	Culbertson, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sidney A. Speer	Illinois	Olive N. Baldwin	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	0	505 26 6174	X Helen L Speer	Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4857

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary sepsis, Cor pulmonale

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 16, 1967, to June 26, 1969, that I last saw the deceased alive on June 25, 1969, and that death occurred at 7:00 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. W. Boyd M.D.	Nampa, Idaho	6/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 30, 1969	Kohlerdown Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Mrs. Martina Walmsley	E. Shepherd	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2749
Local Reg. No. 308
Reg. Dist. No. 360

RECEIVED JUL 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor 216

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1124 Amity Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	SUSAN	HALL	PENN	June	27,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	White	Married 3	Feb. 26, 1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Templemans Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Hall
BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Jeanette (NoRecord)
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-8942
17. INFORMANT'S OWN SIGNATURE Family Records, By: Jay Kroul
ADDRESS Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Parkinson's Disease 342X
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 23, 1948, *to* June 27, 1969, *that I last saw the deceased alive on* 6-18-, 1969, *and that death occurred at* 11:25A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 560 Leroy C. Wesche MD.
23b. ADDRESS Nampa. Idaho
23c. DATE SIGNED 6-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 1, 1969
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery
24d. LOCATION (City, town, or county) Ada County (State) Idaho

DATE REC'D BY LOCAL REG. July 3, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Meservey
LICENSE NO. E-487
FIRM NAME: Alkire Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2750
Local Reg. No. 310
Reg. Dist. No. 360

RECEIVED JUL 8 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (in this place) 886
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor Nursing Home 376

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1111 Belmont St.

3. NAME OF DECEASED (Type or Print) a. (First) Agnes b. (Middle) Iona c. (Last) Campbell
4. DATE OF DEATH (Month) (Day) (Year) June 28, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 24, 1885
9. AGE (In years last birthday) 84
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dawson County, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Owen
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Rebecca Kyle Knox
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 519-09-1994
17. INFORMANT'S OWN SIGNATURE ADDRESS x Ronald E Campbell

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4047

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio Vascular Renal Disease with
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
(b) Chronic Brain Syndrome
DUE TO (c) Arteria Sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-6- *, 1969, to* 6-28- *, 1969, that I last saw the deceased alive on* 6-15- *, 1969, and that death occurred at* 5:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Henry C. Weeks M.D.
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 7-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 2, 1969
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. July 7, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER James R. Dakan
LICENSE NO. E-485
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2751
Local Reg. No. 322
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: CANYON 142 — JUL 11 1969 — 321
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY IN (this place): 21 da.
d. FULL NAME OF HOSPITAL OR INSTITUTION: MERCY HOSPITAL 050

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 523 17th AVE NORTH

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RHODA	AZALIA	SANDERSON	JUNE 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	WIDOWED 2	12/17/1888	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE 01		PARKER, IDAHO	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JAMES MASON	SALT LAKE CITY, UTAH	RHODA HINCKLEY	COLEVILLE UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 2	8		X Gordon T. Sanderson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2001

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Seizure disorder — 15 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/18/ *, 19* 61 *, to* 6/28/ *, 19* 69 *that I last saw the deceased alive on* 6/28/ *, 19* 69 *and that death occurred at* 2:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold W Brown MD	619 So. Canyon, Nampa, Idaho	7/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	7/1/69	KOHLER LAWN CEMETERY	NAMPA, CANYON, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Mrs. Martina Walmsley	E Shepherd	472

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2752
Local Reg. No. 311
Reg. Dist. No. 360

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

141 JUL 1 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): I.O.O.F. Home 195

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Della
b. (Middle): May
c. (Last): Schaefer

4. DATE OF DEATH (Month) (Day) (Year): June 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 21, 1883
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Star, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob Clemens — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Josephine Kingsbury — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 0 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-09-2044D
17. INFORMANT'S OWN SIGNATURE: J.R. Dakan — ADDRESS: 504 So Kimball

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): CVA — 2 wk

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1964, *to* June 28, 1969, *that I last saw the deceased alive on* June 26, 1969, *and that death occurred at* 7 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Neal E Reynolds MD 437
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 7/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: July 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: July 10, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Rodney W. Dakan — LICENSE NO.: E-508

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-1449
BIRTH NO.

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 2753
Local Reg. No. 325
Reg. Dist. No. 360

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN: Nampa
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 313 Yale

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	April	Renee	Cook	June 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married 3	Feb. 11, 1969		4			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
child 02	child	Nampa, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Cook	Arizona	Roberta Breshears	Caldwell, Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 3	no	x Mrs. Roberta Cook	Nampa

884X

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull Fracture - Injury by Fall — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture Rt Femur

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Home	Nampa Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
May 28 69 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Fell at home (1) From Bed (2) From Basket

22. *I hereby certify that I attended the deceased from* 2 June, 19 69 *to* 30 June, 19 69, *that I last saw the deceased alive on* 30 June, 1969, *and that death occurred at* 10 3/4 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R Manzum MD 325	Nampa, Idaho	8 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 2, 1969	Hillcrest Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 14, 1969	Mrs. Martina Walmsley	Richard W. Mesenbrink	E-487

FIRM NAME: Idaho Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUL 11 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2754
Local Reg. No. 315
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 143
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 13 years 113

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1510 Dearborn

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital 052

3. NAME OF DECEASED (Type or Print): a. (First) Douglas; b. (Middle) James; c. (Last) Montgomery

4. DATE OF DEATH: (Month) (Day) (Year): June 30, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: November 23, 1953

9. AGE (In years last birthday): 15
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Aberdeen, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. Lesley Montgomery
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Eleanor Eileen McCluskey
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Wilma Keyser
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Choking on food.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Not seen previously, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 5:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry E. Leisch M.D.

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 7-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-2-1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell Idaho

DATE REC'D BY LOCAL REG.: July 10, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Leonard P. Flahiff

LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 2755
Local Reg. No. 191
Reg. Dist. No. 510

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 150 JUN 13 1969
a. COUNTY Caribou
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA-Caribou Hospital 069

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 112 Rosewood

3. NAME OF DECEASED (Type or Print)
a. (First) THOMAS
b. (Middle) F
c. (Last) MC ATEER

4. DATE OF DEATH (Month) June 6 (Day) 1969 (Year)

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Mar. 2, 1908
9. AGE (In years last birthday) 61 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk 10
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Denver, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles McAteer BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Katherine Floyd BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 4109
16. SOCIAL SECURITY NO. 519-10-6549
17. INFORMANT'S OWN SIGNATURE Mrs Willa McAteer ADDRESS Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 11 P m., from the causes and on the date stated above.*

23a. SIGNATURE 364 C C Herron MD (Degree or title)
23b. ADDRESS Grace, Idaho
23c. DATE SIGNED 10 June 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Jun 10, 1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) Pocatello (State) Idaho

DATE REC'D BY LOCAL REG. JUN 12 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER George W. Knopp
LICENSE NO. 409

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 10 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 18 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

FEB 26 1970

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

DEC 20 1971

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2756
Local Reg. No. 19
Reg. Dist. No. 520-521

BIRTH NO.

RECEIVED
JUN 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Caribou 150
b. CITY OR TOWN Soda Springs
c. LENGTH OF STAY (In this place) 888
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou Memorial Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grace
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Raymond John Thomas

4. DATE OF DEATH (Month) (Day) (Year) June 7, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH April 17, 1896

9. AGE (In years last birthday) 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer-retired 557

10b. KIND OF BUSINESS OR INDUSTRY farming

11. BIRTHPLACE (State or foreign country) Farr West, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Elisha John Thomas
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Eliza Jane Hancock
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) W.W.I 3

16. SOCIAL SECURITY NO. 518-18-1516

17. INFORMANT'S OWN SIGNATURE Elizabeth Thomas
ADDRESS Grace, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

495X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6, 1969, *to* June 7, 1969, *that I last saw the deceased alive on* June 6, 1969, *and that death occurred at* 7:37 a m., *from the causes and on the date stated above.*

23a. SIGNATURE 236 E. E. Gibson MD (Degree or title)
23b. ADDRESS Grace, Idaho
23c. DATE SIGNED 6/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/10/69
24c. NAME OF CEMETERY OR CREMATORY Grace Cemeetery
24d. LOCATION (City, town, or county) (State) Grace, Idaho

DATE REC'D BY LOCAL REG. 6-12-69
REGISTRAR'S SIGNATURE Norene Bunn
25. EMBALMER Leodore Allen
LICENSE NO. E370

FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2757
Local Reg. No. 70
Reg. Dist. No. 520-521

Certificate of Death

RECEIVED JUN 18 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
c. LENGTH OF STAY IN (this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou Memorial Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
d. STREET ADDRESS (If rural, give location) 61 West Third South

3. NAME OF DECEASED (Type or Print) a. (First) Annie b. (Middle) Marie c. (Last) Kassel Gill

4. DATE OF DEATH (Month) (Day) (Year) June 11, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH April 12, 1897

9. AGE (In years last birthday) 72
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Bergenhead, England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Kassel
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Freda Stats
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 3

17. INFORMANT'S OWN SIGNATURE Clyde Gill
ADDRESS Soda Springs Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Thrombophlebitis - Left Leg — Several wks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4510

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 17, 1969, *to* June 10, 1969, *that I last saw the deceased alive on* June 10, 1969, *and that death occurred at* 9:15 a m., *from the causes and on the date stated above.*

23a. SIGNATURE 535 Lenore Tejet (Degree or title) MD

23b. ADDRESS Soda Springs Idaho

23c. DATE SIGNED 6-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6/13/69

24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery

24d. LOCATION (City, town, or county) (State) Soda Springs, Idaho

DATE REC'D BY LOCAL REG. 6-12-69

REGISTRAR'S SIGNATURE Norene Beenn

25. EMBALMER Kendall Allen

LICENSE NO. E370

FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 12 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 11 1977

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2758
Local Reg. No. 22
Reg. Dist. No. 520-521

BIRTH NO.

RECEIVED JUL 1 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY CARIBOU 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) SODA SPRINGS
c. LENGTH OF STAY (in this place) 888
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CARIBOU MEMORIAL HOSPITAL 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY BONNEVILLE 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
d. STREET ADDRESS (If rural, give location) 793 CLEVELAND

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PAUL	GUSTAVE	HARTMAN	JUNE 16 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	WIDOWER 2	AUGUST 1, 1884	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER*RETIRED 39	BUILDING	GERMANY	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
FRANZ HARTMAN	GERMANY	EMMA HARTMAN	GERMANY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	8		Fred Lohman	SODA SPRINGS, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4288 Degenerative H.T. Disease — INTERVAL BETWEEN ONSET AND DEATH 4 weeks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* JUNE 10, 1969, *to* JUNE 16, 1969, *that I last saw the deceased alive on* JUNE 16, 1969, *and that death occurred at* 12:10 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen A. Figuet, MD	Soda Springs, Idaho	6-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 20, 1969	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-24-69	Norene Bunn	Theodore S. Allen	E 370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 2 1992

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2759
Local Reg. No. 21
Reg. Dist. No. 520-521

BIRTH NO. 69-5847 RECEIVED

Certificate of Death

STATE OF IDAHO

JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Caribou 150
b. CITY OR TOWN (If outside corporate limits, write [illegible] township) Soda Springs
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou Memorial Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grace-rural
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Infant Yellowhorse

4. DATE OF DEATH (Month) (Day) (Year) June 16, 1969

5. SEX not determined
6. COLOR OR RACE Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single 1
8. DATE OF BIRTH June 16, 1969
9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR Months 0 Days 0 — IF UNDER 24 HRS. Hours 1 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Soda Springs, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Tommy Yellowhorse — BIRTHPLACE Arizona
14. MOTHER'S MAIDEN NAME Helene Yazzie — BIRTHPLACE Arizona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Tommy Yellowhorse — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7554

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Phocomelia (Newborn) — INTERVAL BETWEEN ONSET AND DEATH 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-16, 1969, *to* 6-16, 1969, *that I last saw the deceased alive on* 6-16, 1969, *and that death occurred at* 8130 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 535 Runce Tigert (Degree or title) MD
23b. ADDRESS Soda Springs Idaho
23c. DATE SIGNED 7-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/17/69
24c. NAME OF CEMETERY OR CREMATORY Central Cemetery
24d. LOCATION (City, town, or county) (State) Central, Caribou, Idaho

DATE REC'D BY LOCAL REG. 7-11-69
REGISTRAR'S SIGNATURE Norene Bunn
25. EMBALMER Theodore S Allen
LICENSE NO. E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2760
Local Reg. No. 93
Reg. Dist. No. 520-521

RECEIVED JUL 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY CARIBOU 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL, SODA SPRINGS
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY BANNOCK 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) POCATELLO
d. STREET ADDRESS (If rural, give location) 337 STANSBURY

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	AFTON	STEEL	GARVIN		June	19	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 10, 1902	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman 10	U.P. Railroad	Lakeview, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOHN M. GARVIN		SARAH ANN STEEL	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 3	XXXX 4189		Richard Garvin	American Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH few minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 19, 1969, *to* June 19, 1969, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 10:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen S. Tigert / MD	Soda Springs, Idaho	6/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
B	June 23, 1969	Mountain View Cemetery	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-24-69	Norene Burns	Theodore S. Allen	E 370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2761
Local Reg. No. 24
Reg. Dist. No. 520-521

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
c. LENGTH OF STAY (in this place) 2 mos. 202
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou Memorial Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paris 040
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Martha b. (Middle) Lucy c. (Last) Kaufmann Lewis Wuthrick

4. DATE OF DEATH (Month) June (Day) 21 (Year) 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Aug. 17, 1897
9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Switzerland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Kaufmann BIRTHPLACE Switzerland
14. MOTHER'S MAIDEN NAME Josephine Kaufmann BIRTHPLACE Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 528-38-4919
17. INFORMANT'S OWN SIGNATURE Mrs. Willard Hansen ADDRESS Paris Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? June

22. *I hereby certify that I attended the deceased from* May 12, 1969, *to* ~~July~~ 21, 1969, *that I last saw the deceased alive on* June 21, 1969 *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23a. SIGNATURE 534 Allen H. Tigert (Degree or title) M.D.
23b. ADDRESS Soda Springs Ida
23c. DATE SIGNED 6/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE June 24, 1969
24c. NAME OF CEMETERY OR CREMATORY Paris Cemetery
24d. LOCATION (City, town, or county) Paris (State) Idaho

DATE REC'D BY LOCAL REG. 7-2-69
REGISTRAR'S SIGNATURE Norene Bunn
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2762
Local Reg. No. 1983
Reg. Dist. No. 470

Certificate of Death

BIRTH NO.

RECEIVED
JUN 11 1969
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (If not in place): 50 years 150
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley - rural
d. STREET ADDRESS (If rural, give location): 400 South 325 East

3. NAME OF DECEASED (Type or Print)
a. (First): Olina
b. (Middle):
c. (Last): Studer

4. DATE OF DEATH (Month) (Day) (Year): June 3, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 11, 1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months 2, Days 23 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lillehammier, Norway
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Amund Berg — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Ingeberg Ulueng — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): -0- - -
16. SOCIAL SECURITY NO.: 518-60-3173T
17. INFORMANT'S OWN SIGNATURE: Marvin Matson — ADDRESS: Burley R.#3 Box 223

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

428X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Frac Rt Femur — 3 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1968, 19—, *to* 6-3-, 1969, *that I last saw the deceased alive on* 6-3, 1969, *and that death occurred at* 10:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 526
23b. ADDRESS: Burley
23c. DATE SIGNED: 6-4-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: June 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: June 9 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2763
Local Reg. No. 1985
Reg. Dist. No. 470

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Cassia 161 JUN 20 1969
b. CITY OR TOWN Burley
c. LENGTH OF STAY (In this place) 60 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 676

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 1242 Almo Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	George	Edward	Huber	June 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct. 3, 1887	81	8	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction Engineer, Burley Irrig.		Deseret, Utah	USA

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
Joseph Edward Huber, Paris France	Zina Dalton, Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No 2 - - -	518-07-6756	Edgar Huber RFD #3 Burley Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Leiomyo Sarcoma - Generalized — INTERVAL BETWEEN ONSET AND DEATH 1719

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Primary Site undetermined ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	none	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
none		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1968, *to* 6-6-, 1969, *that I last saw the deceased alive on* 6-6-, 1969, *and that death occurred at* 8:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
314 R Hutton MD	Burley Idaho	6/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	June 10, 1969	Pleasant View Cemetery,	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 19, 1969	Ruth N. Pearson	Ormand Burch	E-471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

DUTIES:

JUN 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2764
Local Reg. No. 1984
Reg. Dist. No. 470

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUN 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Declo rural
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 850 East 500 South 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Declo
d. STREET ADDRESS (If rural, give location): 118 West Main Street

3. NAME OF DECEASED (Type or Print)
a. (First): Martha
b. (Middle): Lena
c. (Last): Messinger

4. DATE OF DEATH (Month) (Day) (Year): June 13, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 2, 1917
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months 9, Days 11 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Crook, Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Amen — BIRTHPLACE: Russia
14. MOTHER'S MAIDEN NAME: Elizabeth Knopp — BIRTHPLACE: Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): - 0 - -
16. SOCIAL SECURITY NO.: 559-34-9292
17. INFORMANT'S OWN SIGNATURE: Jerome L. Amen — ADDRESS: Route #1 Heyburn Ida.

965X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gun shot wound — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Homicide 0
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 31
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Cassia 160 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 6 13 69 6:30 pm
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: Gun shot wound

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* about 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: C. Bruce Young 583 — (Degree or title): Corner 4
23b. ADDRESS: B urley, Idaho
23c. DATE SIGNED: 6-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: June 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Declo Cemetery
24d. LOCATION (City, town, or county) (State): Declo, Idaho

DATE REC'D BY LOCAL REG.: June 17-69
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

APR 2 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2765
Local Reg. No. 1987
Reg. Dist. No. 470

RECEIVED
JUL 2 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 161 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley, Idaho
LENGTH OF STAY (in this place): few hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley 161
d. STREET ADDRESS (If rural, give location): 1729 Miller Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Maude
b. (Middle):
c. (Last): Fillmore

4. DATE OF DEATH: (Month) June (Day) 14, (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: April 17, 1883

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Mona, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Ferwill
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Anna Metz
BIRTHPLACE: Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-03-0903

17. INFORMANT'S OWN SIGNATURE: X Leslie F. Fillmore
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

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MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident (thrombosis)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: hrs / years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1966, *to* June, 1967, *that I last saw the deceased alive on* 6-14, 1969, *and that death occurred at* 1 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.

23b. ADDRESS: Burley Idaho

23c. DATE SIGNED: 6.26.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6/17/69

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cem.

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: July 1-1969

REGISTRAR'S SIGNATURE: Beth A. Pearson

25. EMBALMER: Jerry K. Lauer E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 1 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 2766
Local Reg. No. 1986
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 — JUN 27 1969
b. CITY OR TOWN: Burley — c. LENGTH OF STAY IN (this place): 2 months 202

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley - rural 160
d. STREET ADDRESS (If rural, give location): 2 miles North 1/2 Mile West

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Peter	Sidley	Nelson, Sr.	June	17,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct. 2, 1904	64	8	15		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 07
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tooele, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward H. Nelson — BIRTHPLACE: Tooele, Utah
14. MOTHER'S MAIDEN NAME: Barbara Gowans, — BIRTHPLACE: Tooele, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 3
(If yes, give war or dates of service): - - 0 - -
16. SOCIAL SECURITY NO.: 518-24-5196
17. INFORMANT'S OWN SIGNATURE: Zella Nelson — ADDRESS: Oakley Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Inanition & Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Bronchogenic Carcinoma ?
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-68
19b. MAJOR FINDINGS OF OPERATION: Bronchogenic Carcinoma
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): None
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): None m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-8-67, *to* 6-17-, 1969, *that I last saw the deceased alive on* 6-16-, 1969, *and that death occurred at* 9:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: 514 R Hutton (Degree or title): MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 6-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: June 21, 1969
24c. NAME OF CEMETERY OR CREMATORY: Oakley Cemetery
24d. LOCATION (City, town, or county) (State): Oakley, Idaho

DATE REC'D BY LOCAL REG.: June 24 1969
REGISTRAR'S SIGNATURE: Ruth A. Pearson
25. EMBALMER: Armand Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

JUL 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 16 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2767
Local Reg. No. 1988
Reg. Dist. No. 470

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 9 weeks 202
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley 161
d. STREET ADDRESS (If rural, give location): 1443 Normal Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Sarah
b. (Middle): Grace
c. (Last): Boothe

4. DATE OF DEATH (Month) (Day) (Year): June 25, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Dec. 27, 1905
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress & Cook 06
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Alamosa, Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William A. Miller — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Mary Hunt — BIRTHPLACE: Alamosa, Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): * 0 * *
16. SOCIAL SECURITY NO.: 519-12-0717
17. INFORMANT'S OWN SIGNATURE: Claude Boothe — ADDRESS: Burley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Toxemia of Oat cell Carcinoma of the Rt lung with metastases — INTERVAL BETWEEN ONSET AND DEATH: 6 to 8 Mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: CVA 10 yr Ag Rt Hemiplegia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-29-48, *19*___, *to* 6-25-69, *19*___, *that I last saw the deceased alive on* 6-25-69, *19*___, *and that death occurred at* 5:03 *Pm., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 526 (Degree or title): M.D.
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 6-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 28, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cem.
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: July 1, 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2768
Local Reg. No. 1989
Reg. Dist. No. 470

69-5890
BIRTH NO.

Certificate of Death

RECEIVED
STATE OF IDAHO

JUL 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 2 days 302
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Albion
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Brandy
b. (Middle): Marie
c. (Last): Dunn

4. DATE OF DEATH (Month) (Day) (Year): June 25, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: June 23, 1969
9. AGE (In years last birthday): –
IF UNDER 1 YEAR: Months – Days 2
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Burley, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard LeRoy Dunn, American Falls, Ida.
14. MOTHER'S MAIDEN NAME: Karen Joyce Hendrick, Butte, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): – – G –
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Richard L. Dunn
ADDRESS: Box 54 Albion Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Cerebral Vascular accident~~ (~~thrombosis~~)
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ~~Arteriosclerosis~~ Immature infant
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: few hrs / years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-23, 1969, *to* 6-25, 1969, *that I last saw the deceased alive on* 6-25, 1969, *and that death occurred at* 10:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 709W [signature] Letterson Md
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 6-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Paul Cemetery
24d. LOCATION (City, town, or county) (State): Paul, Idaho

DATE REC'D BY LOCAL REG.: July 1, 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F. Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 9 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUL 10 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2769
Local Reg. No. 1990
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia (61) 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
LENGTH OF STAY (in this place) 6 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 078

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Cassia (61)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 1729 Miller Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Naomi
b. (Middle) Bowdle
c. (Last) Finley

4. DATE OF DEATH (Month) (Day) (Year) June 27, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Oct. 7, 1878
9. AGE (In years last birthday) 90
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Lore City, Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Bowdle
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary Ann Hopper
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-26-8421
17. INFORMANT'S OWN SIGNATURE Phillip H. Finley
ADDRESS Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture, left femoral neck

19a. DATE OF OPERATION 5-13-69
19b. MAJOR FINDINGS OF OPERATION Fracture, left femoral neck
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-13, 1969, *to* 6-27, 1969, *that I last saw the deceased alive on* 6-27, 1969, *and that death occurred at* 12:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE C Hayden Ellingham (63) (Degree or title) MD
23b. ADDRESS 2233 Overland Avenue Burley, Idaho 83318
23c. DATE SIGNED 7-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/30/69
24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cem.
24d. LOCATION (City, town, or county) (State) Burley, Idaho

DATE REC'D BY LOCAL REG. July 8, 1969
REGISTRAR'S SIGNATURE Bill N. Pearson
25. EMBALMER Jerry K. Lawrence
LICENSE NO. E-522
FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2770
Local Reg. No. 33
Reg. Dist. No. 210

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

180 JUN 9 1969 302

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (In hospital or place): 1 1/2 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst 400
d. STREET ADDRESS (If rural, give location): Pinecreek Star Route

3. NAME OF DECEASED (Type or Print)
a. (First): JUNE
b. (Middle): ETHEL
c. (Last): ELJ

4. DATE OF DEATH (Month) June (Day) 1 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 13, 1931
9. AGE (In years last birthday): 38 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Montana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Owen Brundage — BIRTHPLACE: Montana
14. MOTHER'S MAIDEN NAME: Leona Cooley — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): N/A 0
16. SOCIAL SECURITY NO.: 517-30-6238
17. INFORMANT'S OWN SIGNATURE: Christine Plaude — Records — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — Several years
DUE TO (c): Pulmonary congestion
Diabetes mellitus, juvenile type — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 10, 1969, *to* June 1, 1969, *that I last saw the deceased alive on* May 29, 1969, *and that death occurred at* 10:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 595 Eduardo Herrera, M.D. (Degree or title) — Eduardo Herrera M.D. 1
23b. ADDRESS: Box 672, Orofino, Idaho
23c. DATE SIGNED: June 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 1
24b. DATE: June 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: June 5, 1969
REGISTRAR'S SIGNATURE: June M. Powell
25. EMBALMER: Lyle A. Strollmann — LICENSE NO. 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 2771
Local Reg. No. 34
Reg. Dist. No. 210

Certificate of Death

RECEIVED JUN 9 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 180
a. COUNTY Clearwater 3/2
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (in this place) 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino 180
d. STREET ADDRESS (If rural, give location) 645 Johnson Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) LUCY
b. (Middle) C.
c. (Last) WILES

4. DATE OF DEATH (Month) (Day) (Year) June 2, 1969

5. SEX female
6. COLOR OR RACE Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Apr. 2, 1893
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Ahsahka, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Billie Corbett — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Annie Davis — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 — (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. unknown
17. INFORMANT'S OWN SIGNATURE X Samuel W. Smith — ADDRESS Lapwai

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Congestive Heart failure
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Cholecystitis, Obesity

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/21, 1969, *to* 6/2, 1969, *that I last saw the deceased alive on* 6/2, 1969, *and that death occurred at* 9:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE ~~340~~ 299 (Degree or title) [signature] 1
23b. ADDRESS Orofino, Idaho
23c. DATE SIGNED 4 Jun 69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 1
24b. DATE June 6, 1969
24c. NAME OF CEMETERY OR CREMATORY Ahsahka
24d. LOCATION (City, town, or county) (State) Ahsahka, Idaho

DATE REC'D BY LOCAL REG. June 5, 1969
REGISTRAR'S SIGNATURE June M. Powell
25. EMBALMER Lyle A. Strattmann
LICENSE NO. 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2772
Local Reg. No. 35
Reg. Dist. No. 210

Certificate of Death

RECEIVED
JUN 9 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 9 days 309
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding 240
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Leona
b. (Middle): Marie
c. (Last): Shipley

4. DATE OF DEATH (Month) (Day) (Year): June 3, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Sept. 18, 16
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Shelly, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Betty — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Carrie Fisher — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 3 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-34-9931
17. INFORMANT'S OWN SIGNATURE: x Charles A. Shipley — ADDRESS: Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5718

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hepatic coma — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Bleeding Esophageal varices
DUE TO (c): Biliary cirrhosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Orofino, Clearwater, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 12, 1968, *to* June 3, 1969, *that I last saw the deceased alive on* June 2, 1969, *and that death occurred at* 12:55a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert D. Hill, M.D. 490
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: June 3, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: June 4, 69
24c. NAME OF CEMETERY OR CREMATORY: Thompson F. C.
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: June 4, 1969
REGISTRAR'S SIGNATURE: Josephine K. Duffy
25. EMBALMER: Lyle A. Strottmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Thompson Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 17 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2773
Local Reg. No. 36
Reg. Dist. No. 210

RECEIVED JUN 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pierce-rural
c. LENGTH OF STAY (In this place) unk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Musselshell Road

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino 180
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) HARRIE b. (Middle) A. c. (Last) SNIDER

4. DATE OF DEATH (Month) (Day) (Year): June 10, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: Nov. 2, 1909

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: construction

11. BIRTHPLACE (State or foreign country): Wardner, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry R. Snider
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: unknown
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-03-6453

17. INFORMANT'S OWN SIGNATURE X [signature] ADDRESS Lewiston

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4209

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Never, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 583 (Degree or title) Coroner

23b. ADDRESS Orofino, Idaho

23c. DATE SIGNED June 14, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE June 16, 69

24c. NAME OF CEMETERY OR CREMATORY: Riverside

24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG. June 19, 1969

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER [signature] LICENSE NO. 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2774
Local Reg. No. 37
Reg. Dist. No. 210

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater JUN 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY IN THIS PLACE: Moments
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 Miles So. of Fraser on State Hi-Way #11

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pierce
d. STREET ADDRESS (If rural, give location): P O Box 114

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
TIMOTHY	RAY	CLEVELAND	13 June 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	14 July 1951	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Woodsman	C.P.T.P.A.	Orofino, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Don C. Cleveland	Idaho	Nell Curry	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518 62 3717	Mrs Nell Cleveland	Pierce, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemo Thorax & Pneumo Thorax — INTERVAL BETWEEN ONSET AND DEATH: Moments

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ruptured Spleen, Liver, vascular System.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Dullax Rd.	Rural Pierce, Clearwater Co., Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Approx 13 June 1969 9:30AM	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Truck rolled over body after falling from running board

22. *I hereby certify that I attended the deceased from* Never, 19__ *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 10:10 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Coroner	Orofino, Idaho	14 June 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	Burial 16 June 1969	Lewis-Clark Memo. Gard	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 19, 1969	June M. Powell	W E Black	E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2775
Local Reg. No. 38
Reg. Dist. No. 210

STATE OF IDAHO

RECEIVED

JUN 23 1969

Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Clearwater 180

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino

c. LENGTH OF STAY (in this place): 10 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Clearwater

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural 180

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)

a. (First): LAWRENCE

b. (Middle):

c. (Last): KOERLING

4. DATE OF DEATH (Month) (Day) (Year): June 14, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: May 31, 1884

9. AGE (In years last birthday): 85

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: grain-cattle

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Koerling

BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Theresa Kale

BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 3

(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 518-05-1673

17. INFORMANT'S OWN SIGNATURE: William Koerling

ADDRESS: Orofino

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Septicemia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Gangrene Rt Leg.

DUE TO (c): Peripheral Vascular Insufficiency

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: AB. Generalized.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 4, 1969, *to* June 14, 1969, *that I last saw the deceased alive on* June 14, 1969, *and that death occurred at* 10:50 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Orofino Idaho

23c. DATE SIGNED: 18 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: June 17, 69

24c. NAME OF CEMETERY OR CREMATORY: Riverside

24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: June 19, 1969

REGISTRAR'S SIGNATURE: Irene M. Powell

25. EMBALMER

LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2776
Local Reg. No. 40
Reg. Dist. No. 210

RECEIVED
JUN 23 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater (180) (303)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orfino
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. (073)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural (180)
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	FRED	AVERY	June 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	unknown	Sept. 9, 1912	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 06	farm & varied	Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Avery	Unknown	Alice L. Bails	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unknown	0	500-07-2369	Lyle A. Gilbertson	Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY EMPHESEMA — INTERVAL BETWEEN ONSET AND DEATH: 5 YRS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

492X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-14, 1969 *to* 6-16, 1969 *that I last saw the deceased alive on* 6-15, 1969 *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
430 C.K. Reba MD	Orofino, Idaho	6/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	June 20, 69	Riverside	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 19, 1969	Irene M. Powell	Lyle A. Gilbertson	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2777
Local Reg. No. 39
Reg. Dist. No. 210

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUN 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (If not in place): 3 yr. 5 mo. 103
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Viola 290
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): DONNA
b. (Middle): MAY
c. (Last): PIXLEY

4. DATE OF DEATH (Month) (Day) (Year): June 16 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 9, 1887
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sherman Judd — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Josie Duncan — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown 3 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Christine Blonde — Records — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: chronic

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Pneumonitis — 22 days
DUE TO (c): Pulmonary embolism — 1 week

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Senility — Several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 24, 1969, *to* June 16, 1969, *that I last saw the deceased alive on* June 16, 1969, *and that death occurred at* 1:40 p m., *from the causes and on the date stated above.*

23a. SIGNATURE C. A. Cleto (Degree or title): M.D. 595
23b. ADDRESS: Box 672, Orofino, Idaho
23c. DATE SIGNED: June 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: June 20, 69
24c. NAME OF CEMETERY OR CREMATORY: Viola Cemetery
24d. LOCATION (City, town, or county) (State): Viola, Idaho

DATE REC'D BY LOCAL REG.: June 19, 1969
REGISTRAR'S SIGNATURE: June M. Powell
25. EMBALMER: [signature]
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SHORT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2778
Local Reg. No. 41
Reg. Dist. No. 210

BIRTH NO.

RECEIVED
JUN 30 1969
Bureau of Vital Statistics

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater (180)
b. CITY OR TOWN: Orofino
c. LENGTH OF STAY IN THIS [illegible]: 12 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. (073)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural (180)
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): THEODORE
b. (Middle): ROOSEVELT
c. (Last): BLAKE

4. DATE OF DEATH (Month) (Day) (Year): June 20, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 3, 1898

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): woods worker (17)

10b. KIND OF BUSINESS OR INDUSTRY: lumber

11. BIRTHPLACE (State or foreign country): Orofino, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edwin Blake
BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Minnie Davies
BIRTHPLACE: Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): (3)

16. SOCIAL SECURITY NO.: 518-10-8326

17. INFORMANT'S OWN SIGNATURE: Thelma Blake
ADDRESS: Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

(4109)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Myocardial Infarction
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 20, 1969, *to* June 20, 1969, *that I last saw the deceased alive on* June 20, 1969, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: 23 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: June 23, 69
24c. NAME OF CEMETERY OR CREMATORY: Weseman
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: June 27, 1969
REGISTRAR'S SIGNATURE: June M. Cowell
25. EMBALMER: [signature]
LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2779
Local Reg. No. 42
Reg. Dist. No. 210

BIRTH NO.

RECEIVED JUL 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN Orofino - rural
c. LENGTH OF STAY (in this place) minn.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U. S. Highway 12 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino-rural 180
d. STREET ADDRESS (If rural, give location) route 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DENNIS	ARTHUR	NEUMAYER	June 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	never married	July 15, 1955	13				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur C. Neumayer — BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Florence Jordan — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 8
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE X [signature] ADDRESS Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken neck & internal injuries — INTERVAL BETWEEN ONSET AND DEATH: minn.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

8136

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) U. S. Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) Orofino, 13 (COUNTY) Clearwater, (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 27, 69 4 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Struck by auto while on bicycle

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	coroner	Orofino, Idaho	June 28, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	June 30, 69	Riverside	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 2, 1969	June M. Powell	[signature]	176

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2780
Local Reg. No. 43
Reg. Dist. No. 210

RECEIVED JUL 3 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 10 yrs. 110
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hospital 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino 180
d. STREET ADDRESS (If rural, give location): Orofino Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): TRENT
b. (Middle): EDWARD
c. (Last): RICHEY

4. DATE OF DEATH (Month) (Day) (Year): june 27, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: Sept. 16, 1954
9. AGE (In years last birthday): 14 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Portland, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dr. Glenn Richey — BIRTHPLACE: Boulder, Colo
14. MOTHER'S MAIDEN NAME: Denise Rawson — BIRTHPLACE: Portland, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 8
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Glenn A. Richey — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8136

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Head Injuries

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE XX (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 12 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 2 miles West Orofino, Clearwater, Idaho 13 180
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile struck bicycle

22. *I hereby certify that I attended the deceased from* June, 1960, *to* June, 1969, *that I last saw the deceased alive on* 27 June, 1969, *and that death occurred at* 5.32 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 299 [signature] 1
23b. ADDRESS: Orofino Idaho
23c. DATE SIGNED: 30 Jun 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: June 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: July 2, 1969
REGISTRAR'S SIGNATURE: June M. Lowell
25. EMBALMER: Patrick Mahoney
LICENSE NO.: E-492

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Merchant Funeral Home Clarkston Wn.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2781
Local Reg. No. 3
Reg. Dist. No. 680

BIRTH NO.

RECEIVED
JUN 10 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Custer (190)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
c. LENGTH OF STAY (In this place): 40 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis (190)
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Halsey	Merritt	Gridley	June 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	April 5, 1894	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Newspaper Published	and Editor	Westfield, Penn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles L. Gridley	Penn.	Olivia Ann Knapp	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW #1	518-09-1849	Halsey Elwin Gridley	Challis, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: -0-

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 1 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ralph Potter 583 Custer Co. Coroner	Challis, Idaho	6-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-6-69	Challis	Challis, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-7-69	Pauline J. Mulder	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

JUN 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2782
Local Reg. No. 2
Reg. Dist. No. 680

RECEIVED JUL 8 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Custer 190
b. CITY OR TOWN Challis
LENGTH OF STAY (in this place) 35 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gene Riggs residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Challis
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) BLISS
c. (Last) RIGGS

4. DATE OF DEATH (Month) (Day) (Year) June 30, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Aug. 29, 1881
9. AGE (In years last birthday) 87
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 84
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Galt, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Riggs
BIRTHPLACE Unobtainable
14. MOTHER'S MAIDEN NAME Mollie (MNU)
BIRTHPLACE Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) 8
16. SOCIAL SECURITY NO. 519-32-3020
17. INFORMANT'S OWN SIGNATURE Gene Riggs
ADDRESS Challis Ida

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY OCCLUSION

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 3:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE Ralph Potter 583
(Degree or title) Coroner
23b. ADDRESS Challis Idaho
23c. DATE SIGNED 7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.-Burial
24b. DATE 7-5-69
24c. NAME OF CEMETERY OR CREMATORY Berry Cemetery
24d. LOCATION (City, town, or county) Galt, Missouri (State)

DATE REC'D BY LOCAL REG. 7-7-69
REGISTRAR'S SIGNATURE Pauline J. Mulder
25. EMBALMER E. H. Marvel
LICENSE NO. E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2783
Local Reg. No. 49
Reg. Dist. No. 380 391

Certificate of Death

BIRTH NO. 69-5922 RECEIVED STATE OF IDAHO

JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): Mountain Home

3. NAME OF DECEASED (Type or Print)
a. (First): BABY
b. (Middle): GIRL
c. (Last): PATINO

4. DATE OF DEATH (Month) (Day) (Year): June 4, 1969

5. SEX: Female
6. COLOR OR RACE: Sp-Am.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: June 4, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mountain Home, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Francisco Patino
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME:
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: + Francisco Patino
ADDRESS: Mt. Home

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7611 Premature
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Maternal diabetes
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 623 Novell M. Weeks MD
23b. ADDRESS: Mt Home Ida.
23c. DATE SIGNED: 6-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/6/69
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: July 3 1969
~~REGISTRAR'S SIGNATURE~~: P. Anderson
25. EMBALMER: H. Weil Humphrey
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2784
Local Reg. No. 50
Reg. Dist. No. 380 391

RECEIVED JUL 15 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 209
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Mtn. Home
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1½ miles No. Mt. Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Mountain Home
d. STREET ADDRESS (If rural, give location): 1½ Miles North of Mtn. Home

3. NAME OF DECEASED (Type or Print): a. (First) WALLACE b. (Middle) H. c. (Last) FINN

4. DATE OF DEATH (Month) (Day) (Year): June 7, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 28, 1915

9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Ranch

11. BIRTHPLACE (State or foreign country): Layton, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Wm. Finn — BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Cloey Whitaker — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War 1

16. SOCIAL SECURITY NO.: 518-09-9015

17. INFORMANT'S OWN SIGNATURE: Elsie M. Finn — ADDRESS: Mtn. Home, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) apoxia, Carpulmonale

DUE TO (c) Chronic Emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Russell Weeks MD

23b. ADDRESS: Mt Home

23c. DATE SIGNED: 6-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6/11/69

24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery

24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: July 3 1969

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature]

LICENSE NO.: E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 31 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2785
Local Reg. No. 43
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED JUN 17 1969 Bureau of Vital Statistics STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Elmore 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Home
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore County Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry 83623
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) W. c. (Last) KINGSTON

4. DATE OF DEATH (Month) (Day) (Year): June 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Aug. 31, 1906	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Auto	Bowbells, No. Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Kimgston	unk.	unk.	unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	---- 8	518-22-7531	Stella M. Kingston	525 Main West T.F.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4411

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dissecting Aneurysm of The Thoracic Aorta

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 12 noon *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry W. Wells M.D.	Mountain Home, Idaho	6/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/11/69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 13 1969	[signature]	[signature]	E- 572

FIRM NAME: White Mortuary Twin Falls

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2786
Local Reg. No. 38
Reg. Dist. No. 380 491

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUN 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Rest Home 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 430 No. 8th East

3. NAME OF DECEASED (Type or Print)
a. (First): SADIE
b. (Middle): BOYD
c. (Last): CLASS

4. DATE OF DEATH (Month) (Day) (Year): June 9, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 10, 1876
9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Erie, Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Gushard — BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Anna Clow — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 4122
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Alice E. Monasterio — ADDRESS: Mtn. Home, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): H.C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cerebral vascular accidents (repeated) — months

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1966, *to* June, 1969, *that I last saw the deceased alive on* June 9, 1969, *and that death occurred at* 1:20 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Malone Woolsch M.D. 289
23b. ADDRESS: Mountain Home Idaho
23c. DATE SIGNED: June 12 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 6/11/69
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Brighton, Colorado

DATE REC'D BY LOCAL REG.: Jun 10 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Arthur Smith
LICENSE NO.: E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2787
Local Reg. No. 51
Reg. Dist. No. 380 391

RECEIVED JUL 15 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Elmore 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt Home AFB
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 67 Tac Hosp, Mt Home AFB ID 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 455 Noth 3rd East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lewis	Joe	Arambarri	June	20	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Caucasian	Married 3	14 May 1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Property Specialist
10b. KIND OF BUSINESS OR INDUSTRY: Civil Service
11. BIRTHPLACE (State or foreign country): Gooding, Idaho
12. CITIZEN OF WHAT COUNTRY? USAF

13. FATHER'S NAME: Turbico 08 — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Alberdi — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 2 1Apr41-26Jun45 4789
16. SOCIAL SECURITY NO.: 518-10-7942
17. INFORMANT'S OWN SIGNATURE: Betty M. Arambarri — ADDRESS: Mt. Home, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardiac arrest	45 min
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Acute myocardial infarction	60 min
DUE TO (c)	Atherosclerotic heart disease	10 years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Jun, 19 69, *to* 20 Jun, 19 69, *that I last saw the deceased alive on* 20 Jun 69, 19 ___, *and that death occurred at* 2:32 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
PAUL [illegible] M.D.	67 Tac Hospital, Mt Home AFB ID	20 Jun 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 24, 1969	Glen Rest Cemetery	Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 3 1969	[illegible] Anderson	H. Vern Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 7 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2788
Local Reg. No. 47
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Anderson Ranch Dam
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anderson Ranch Dam 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: Kern 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bakersfield 555
d. STREET ADDRESS (If rural, give location): 1401 Ridgeview

3. NAME OF DECEASED (Type or Print): a. (First) STEPHEN b. (Middle) ALLEN c. (Last) MORRIS

4. DATE OF DEATH (Month) (Day) (Year): June 29, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 7

8. DATE OF BIRTH: July 18, 1951

9. AGE (In years last birthday): 17
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: High School

11. BIRTHPLACE (State or foreign country): Council Bluff, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Guy Morris
BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Margaret Shupe
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 574-X

17. INFORMANT'S OWN SIGNATURE: L. L. Shupe
ADDRESS: Bakersfield, Cal

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Asphyxiation
INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Carbon Monoxide Poisoning
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): pick-up camper 27
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Mountain Home 13, Elmore 300, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 29, 1969 1:00 A
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Charcoal broiler placed in camper for warmth.

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation only, 19__, *to* 19__, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 1:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith 283 (Degree or title): Coroner
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 6/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Removal
24b. DATE: 6/30/69
24c. NAME OF CEMETERY OR CREMATORY: Bakersfield, Calif.
24d. LOCATION (City, town, or county) (State): Bakersfield, California

DATE REC'D BY LOCAL REG.: July 8 1969
REGISTRAR'S SIGNATURE:
25. EMBALMER: H Del Humphreys
LICENSE NO.: E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2789
Local Reg. No. 46
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Elmore 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Anderson Ranch Dam
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Anderson Ranch Dam 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY Kern 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bakersfield
d. STREET ADDRESS (If rural, give location) 1401 Ridgeview

3. NAME OF DECEASED (Type or Print)
a. (First) BELVIN
b. (Middle) HENRY
c. (Last) SHUPE

4. DATE OF DEATH (Month) (Day) (Year) June 29, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 2

8. DATE OF BIRTH Nov. 29, 1925

9. AGE (In years last birthday) 44
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Kansas

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Leslie Shupe
BIRTHPLACE Virginia

14. MOTHER'S MAIDEN NAME Opal Wilcox
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) O
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE L. S. Shupe
ADDRESS Bakersfield, Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carbon Monoxide Poisoning
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Pick-up camper

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Mountain Home, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 29, 1969 1:00

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Charcoal broiler placed in camper for warmth.

22. *I hereby certify that I attended the deceased from* did not see alive, investigation only *to* ____, 19____, *and that death occurred at* 1:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE Arthur Smith (Degree or title) Coroner
23b. ADDRESS Mountain Home, Idaho
23c. DATE SIGNED 6/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/30/69
24c. NAME OF CEMETERY OR CREMATORY Bakersfield, Calif.
24d. LOCATION (City, town, or county) (State) Bakersfield, California

DATE REC'D BY LOCAL REG. July 8 1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Arthur Smith
LICENSE NO. E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 14 1991

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2790
Local Reg. No. 19
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 210 JUN 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Utah 45
b. COUNTY Weber 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Roy
d. STREET ADDRESS (If rural, give location) 4910 South 2275 West

3. NAME OF DECEASED (Type or Print)
a. (First) LINDA
b. (Middle) SUE
c. (Last) MUTTI

4. DATE OF DEATH (Month) 6 (Day) 6 (Year) 69

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married 1
8. DATE OF BIRTH Aug. 6, 1953
9. AGE (In years last birthday) 15 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) South Bend, Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles A. Mutti — BIRTHPLACE Mishawaka, Indiana
14. MOTHER'S MAIDEN NAME Donna Layne — BIRTHPLACE Lewiston, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs. Raymond L. New — ADDRESS Roy, Utah

18. CAUSE OF DEATH 3459
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Convulsion Epileptic — INTERVAL BETWEEN ONSET AND DEATH 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Epilepsy — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 6, 1969, *to* 6 6, 1969, *that I last saw the deceased alive on* Dead, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 122 C. R. Cutler (Degree or title) Md
23b. ADDRESS Preston Idaho
23c. DATE SIGNED 6 6 69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE June 9, 1969
24c. NAME OF CEMETERY OR CREMATORY Memorial Gardens Wasatch
24d. LOCATION (City, town, or county) South Ogden, Utah (State)

DATE REC'D BY LOCAL REG. 6-9-69
REGISTRAR'S SIGNATURE Eugene W. Brower
25. EMBALMER O. Sherwin Webb — LICENSE NO. 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Lindquist & Sons Ogden, Utah

DUTIES:

JUN 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Leo Hawkes

Certificate of Death

RECEIVED
JUN 24 1969
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2791
Local Reg. No. 20
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Preston Hospital 187

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairview
d. STREET ADDRESS (If rural, give location): Fairview, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) CAROLINE b. (Middle) SMITH c. (Last) HALL

4. DATE OF DEATH (Month) (Day) (Year): JUNE 11, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Dec. 19-1884
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 01 Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Richmond, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Charles Smith -Burbidge, England
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Honor Rawlings -Burbidge, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: -
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Burtis R. Hall Fairview, Idaho

4369

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Fracture left hip

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, *19* 46 *to* 6/11, *19* 69, *that I last saw the deceased alive on* 6/11, *19* 69, *and that death occurred at* 9:00am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 214 Leo R. Hawkes M.D.
23b. ADDRESS: Preston, Idaho
23c. DATE SIGNED: 6/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cem.
24d. LOCATION (City, town, or county) (State): Fairview, Idaho

DATE REC'D BY LOCAL REG.: 6-14-69
REGISTRAR'S SIGNATURE: Effie W. Brower
25. EMBALMER: W Loyal Hall
LICENSE NO.: E-268

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: HALL MORTUARY-

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 2 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2792
Local Reg. No. 21
Reg. Dist. No. 540

Certificate of Death

RECEIVED
JUN 24 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (Whole place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Preston Hospital 187

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston 210
d. STREET ADDRESS (If rural, give location): 60 West 4th South

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Hyrum Smith Peterson

4. DATE OF DEATH (Month) (Day) (Year): June 12, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower 2
8. DATE OF BIRTH: Sept. 18, 1888
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman-retired 29
10b. KIND OF BUSINESS OR INDUSTRY: U.P.& L. Co.
11. BIRTHPLACE (State or foreign country): Aalborg, Denmark
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Niels Peterson — BIRTHPLACE: Denamark
14. MOTHER'S MAIDEN NAME: Meta Peterson — BIRTHPLACE: Denamark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): W.W.I 3
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Hyrum Bay Peterson — ADDRESS: Idaho Preston

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Corpulmonale — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Pulmonary fibrosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Emphysema

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 19 65, *to* June 12, 19 69, *that I last saw the deceased alive on* June 12, 19 69, *and that death occurred at* 7:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 214 Leo R. Hawkes M.D.
23b. ADDRESS: Preston, Idaho
23c. DATE SIGNED: 6/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 6/16/69
24c. NAME OF CEMETERY OR CREMATORY: Grace Cemetery
24d. LOCATION (City, town, or county) (State): Grace, Idaho

DATE REC'D BY LOCAL REG.: 6-21-69
REGISTRAR'S SIGNATURE: Eggie W. Brower
25. EMBALMER: Theodore S. Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2793
Local Reg. No. 32
Reg. Dist. No. 540

BIRTH NO.

RECEIVED JUL 15 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Franklin 210

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston

c. LENGTH OF STAY (In this place): 2 Mo. 302

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Arizona 03

b. COUNTY: 555

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Winslow

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)

a. (First): Eunice

b. (Middle):

c. (Last): Joey

4. DATE OF DEATH (Month) (Day) (Year): June 21, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): /

8. DATE OF BIRTH: Not known

9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Castle Butte, Ariz.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Joey — BIRTHPLACE: Not Known

14. MOTHER'S MAIDEN NAME: Mary — BIRTHPLACE: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: /s/ Gaylord Larson — ADDRESS: Preston, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Penetrating L. ant chest wound c/ Pneumothorax and Probable myocardial Contusion — INTERVAL BETWEEN ONSET AND DEATH: 45 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway - #34

21c. (CITY, TOWN, OR TOWNSHIP): Preston — (COUNTY): Franklin — (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Automobile Accident

22. I hereby certify that I attended the deceased from 6/21, 1969, to None, 19—, that I last saw the deceased alive on 6/21, 1969, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Jonathan H. Davis MD

23b. ADDRESS: Preston Idaho

23c. DATE SIGNED: 6/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial

24b. DATE: June 25, 69

24c. NAME OF CEMETERY OR CREMATORY: Winslow Cemetery

24d. LOCATION (City, town, or county) (State): Winslow, Arizona

DATE REC'D BY LOCAL REG.: 6-30-69

REGISTRAR'S SIGNATURE: Effie W. Brower

25. EMBALMER: O. Sherwin Webb — LICENSE NO.: ~~252~~ 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

State File No. 2794
Local Reg. No. 23
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 210 108
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 8 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 146 North State 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 146 North State

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Cecelia Rose Kelly Petterborg

4. DATE OF DEATH (Month) (Day) (Year): June 22, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 10, 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas J. Kelly — BIRTHPLACE: Ireland
14. MOTHER'S MAIDEN NAME: Ellen Creeden — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No 3
16. SOCIAL SECURITY NO.: 518 50 5884
17. INFORMANT'S OWN SIGNATURE: Donald F Petterborg — ADDRESS: Clearfield, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1968, *to* June 22, 1969, *that I last saw the deceased alive on* June 22, 1969, *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. R. Cutler MD
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 6 23 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 26, 1969
24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery
24d. LOCATION (City, town, or county) (State): Preston, Idaho

DATE REC'D BY LOCAL REG.: 6-26-69
REGISTRAR'S SIGNATURE: Eppie W. Brower
25. EMBALMER: O. Sherwin Webb — LICENSE NO. ~~252~~ 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2795
Local Reg. No. 240
Reg. Dist. No. 540

RECEIVED JUL 15 1969 Bureau of Vital

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
c. LENGTH OF STAY (in this place) 1 Day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) WARREN b. (Middle) LEROY c. (Last) PETTERBORG

4. DATE OF DEATH (Month) (Day) (Year): June 26, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 7

8. DATE OF BIRTH: May 2, 1884

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Retiret) 29

10b. KIND OF BUSINESS OR INDUSTRY: Dairy

11. BIRTHPLACE (State or foreign country): Preston, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Emil O. Petterborg — BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Eureka Lundgran — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service) 2 0

16. SOCIAL SECURITY NO.: 518 46 9107

17. INFORMANT'S OWN SIGNATURE: Per O. Petterborg — ADDRESS: Preston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) STOKES Adams Seizure — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Complete Heart Block - 2 years

DUE TO (c) Probable OLD - Myocardial Infarction 10 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/25, 1968, *to* 6-26, 1969, *that I last saw the deceased alive on* 6-26, 1969, *and that death occurred at* 10:15 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.A. — **23b. ADDRESS**: Preston Idaho — **23c. DATE SIGNED**: 7-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: June 30, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Preston Cemetery — **24d. LOCATION** (City, town, or county) (State): Preston, Idaho

DATE REC'D BY LOCAL REG.: 7-3-69 — REGISTRAR'S SIGNATURE: Esther W. Brouwer

25. EMBALMER: O. Sherwin Webb — LICENSE NO.: 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2796
Local Reg. No. 12
Reg. Dist. No. 231

RECEIVED JUN 27 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mack's Inn
c. LENGTH OF STAY (in this place) One day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 970 Elmore

3. NAME OF DECEASED (Type or Print) a. (First) BERT b. (Middle) c. (Last) ROWE

4. DATE OF DEATH (Month) (Day) (Year) June 14,1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct.25,1910

9. AGE (In years last birthday) 58
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector 08

10b. KIND OF BUSINESS OR INDUSTRY Dept of Agriculture

11. BIRTHPLACE (State or foreign country) Rigby,Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph M Rowe
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Josephine Thompson
BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) 3 0

16. SOCIAL SECURITY NO. 519 07 4100 4109

17. INFORMANT'S OWN SIGNATURE ADDRESS
✓ Irene Rowe Idaho Falls,Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE Paul Rowell (Degree or title) Coroner
23b. ADDRESS Box 170 St Anthony,Idaho
23c. DATE SIGNED 6-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/18/69
24c. NAME OF CEMETERY OR CREMATORY Rigby Pioneer Cemetery
24d. LOCATION (City, town, or county) (State) Rigby,Idaho

DATE REC'D BY LOCAL REG. 26 June 69
REGISTRAR'S SIGNATURE M D Hansen
25. EMBALMER Jack A. Wood, Jr.
LICENSE NO. 396
FIRM NAME: WOOD FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 1 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2797
Local Reg. No. 37
Reg. Dist. No. 651

RECEIVED JUL 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
LENGTH OF STAY (in this place) 2 wks 3/4
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
d. STREET ADDRESS (If rural, give location) North of Ashton

3. NAME OF DECEASED (Type or Print) a. (First) OTTO b. (Middle) c. (Last) STURM

4. DATE OF DEATH (Month) (Day) (Year) June 18, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 12 Jan. 1889
9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Voldeck, Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Johann Sturm BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Ida Kandler BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 3
16. SOCIAL SECURITY NO. 519-40-2893A
17. INFORMANT'S OWN SIGNATURE Donald Sturm ADDRESS Ashton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease, chronic — 4 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — 5 yrs
Cerebral Thrombosis
Chronic brain syndrome

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1969, *to* June 18, 1969, *that I last saw the deceased alive on* June 18, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE 398 (Degree or title)
23b. ADDRESS Ashton - Idaho
23c. DATE SIGNED 7-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-21-1969
24c. NAME OF CEMETERY OR CREMATORY Pineview Cemetery
24d. LOCATION (City, town, or county) (State) Ashton, Idaho

DATE REC'D BY LOCAL REG. 17 July 69
REGISTRAR'S SIGNATURE M. L. Hansen
25. FUNERAL DIRECTOR Robert O. Beam
ADDRESS E456 Ashton, Idaho

Federal Security Agency
United States Public Health Service
Form DPH-48021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 2798
Local Reg. No. 22
Reg. Dist. No. 651

RECEIVED
Bureau of Vital Statistics
JUL 23 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
c. LENGTH OF STAY IN (Place) 088
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
d. STREET ADDRESS (If rural, give location) None Given

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LEE	AXEL	ANDERSON	June 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	31 Aug. 1900	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Boarp, Sweden	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oscar Anderson	Sweden	Ida Krestena GLAD	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 3	519-38-3529	Henrietta Anderson	Ashton, Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — 5 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-19-69 *to* ____, 19__, *that I last saw the deceased alive on* 6-19-, 1969 *and that death occurred at* 4:45A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
298		Ashton - Idaho	7-(6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-23-1969	Pineview Cemetery	Ashton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
17 July 69		Robert Bean	E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUL 1 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2799
Local Reg. No. 221
Reg. Dist. No. 650

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 221
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 220 East 3rd North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony 221
d. STREET ADDRESS (If rural, give location): 220 East 3rd North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MOLLIE	shirley	KOOCH	June 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Never Married 7	2 Dec 1897	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Telephone Operator 69	(MST&T Co.) Retired	Rea, Fremont County. Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Kooch	Ashville, Tenn	Margaret McAlpine	Busby, Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	0	518-07-1993	John E Kooch	RFD#1 Weiser, Idaho 83672

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 11 P.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul Powell 583 coroner	St. Anthony, Idaho	24 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	24 June 69	Riverview Cemetery	St. Anthony, Fremont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
30 June 69	M L Hansen	M. D. Hansen M L Hansen	E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 2 1969

APR 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 1 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2800
Local Reg. No. 16
Reg. Dist. No. 650

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 33
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 082 Fremont General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony 221
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ULYSSES		BIRCH	June 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married 3	March 1, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dry Cleaner operator- Retired		Wilford, Fremont County, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Birch 29	Hoytsville, Utah	Elizabeth Janet White	Willard, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
C	C	518-22-2588	Vivian Hardcastle	St. Anthony, Idah

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary insufficiency — 1 yr

DUE TO (c) Chronic Myocarditis — 9 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/21, 1969, *to* 6/22, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 11:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
488 C. L. Soule MD	St. Anthony, Idaho	25 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	25 June 69	Wilford Cemetery	St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
28 June 69	M. D. Hansen	M. D. Hansen	E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2801
Local Reg. No. 231
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 22
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
LENGTH OF STAY (in this place) 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Fremont 22
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) none given

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROLAND	ADELBERT	COBURN	June 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Dec 5, 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Macwahoc, Maine	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ernest Coburn	unknown	Cora Weston	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-10-9116	Family Records Robert Bean	Ashton, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia	8d
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	C H F	8 yrs
DUE TO (c)	Emphysema	10 yrs
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1969, *to* June 25, 1969, *that I last saw the deceased alive on* June 25, 1969, *and that death occurred at* 12:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lloyd Burt M D	St Anthony Idaho	7-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 30, 1969	Pineview Cemetery	Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
18 July 69	Mal Hansen	Robert Bean	E456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2802
Local Reg. No. 33
Reg. Dist. No. 240 241

BIRTH NO.

RECEIVED JUL 2 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 23
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 4 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shady Lane Nursing Home 265

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Gem 23
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sweet 05
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print): a. (First) Alfred; b. (Middle); c. (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year): May 26, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 4

8. DATE OF BIRTH: May 22, 1887

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR Months: 0 Days: 4 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Park City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jonas Johnson — BIRTHPLACE: Linn, Sweden

14. MOTHER'S MAIDEN NAME: Ida Victoria Smith — BIRTHPLACE: Heber, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 519-03-0740A

17. INFORMANT'S OWN SIGNATURE: X Loneta Grace Ashley — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): C V A — INTERVAL BETWEEN ONSET AND DEATH: 2 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* 5-26, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 5:15A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: May 29, 1969

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: June 23 1969

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty — LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 10 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED JUN 24 1969 Bureau of Vital Statistics STATE OF IDAHO

State File No. 2803
Local Reg. No. 30
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 25
b. CITY OR TOWN: Emmett
c. LENGTH OF STAY (In this place): 32 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mounted Route 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 25
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Mounted Route

3. NAME OF DECEASED (Type or Print): a. (First) Hans b. (Middle) c. (Last) Bratvold

4. DATE OF DEATH (Month) (Day) (Year): June 11, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Aug. 31, 1892

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR Months: 9 Days: 10 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): grader

10b. KIND OF BUSINESS OR INDUSTRY: lumber

11. BIRTHPLACE (State or foreign country): Norway

12. CITIZEN OF WHAT COUNTRY?: UNKNOWN

13. FATHER'S NAME: Ole Bratvold — BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Hannah Lystig — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-07-3557

17. INFORMANT'S OWN SIGNATURE: X Owen G. Bratvold — ADDRESS: Coeur d'Alene Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4107

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Never., 19___, *to* ~~June 11~~, 19~~69~~, *that I last saw the deceased alive on* about June 9, 1969, *and that death occurred at* approx 10:00 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Glenn W Beatty S83 Coroner Gem Co. — **23b. ADDRESS**: Emmett Idaho — **23c. DATE SIGNED**: June 20-1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: June 16, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Emmett — **24d. LOCATION** (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: June 20, 1969 — REGISTRAR'S SIGNATURE: Glenn A Beatty

25. EMBALMER: Glenn W Beatty — LICENSE NO.: E-362

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2804
Local Reg. No. 31
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED
JUN 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN Emmett
c. LENGTH OF STAY (in this place) 401 Hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION Walter Knox Memorial 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Gem 231
c. CITY OR TOWN Sweet
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) EDWARD c. (Last) KIRKPATRICK

4. DATE OF DEATH (Month) (Day) (Year) June 15, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4
8. DATE OF BIRTH August 22 1908
9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months 9 Days 23 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) patrol operator 11
10b. KIND OF BUSINESS OR INDUSTRY construction
11. BIRTHPLACE (State or foreign country) Sweet, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John James Kirkpatrick BIRTHPLACE Mexico, Mo.
14. MOTHER'S MAIDEN NAME Anna Stevens BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-03-1315
17. INFORMANT'S OWN SIGNATURE X James M. Kirkpatrick ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PROBABLE PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH 2 HOURS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) SEVERE ARTERIOSCLEROSIS — 10 YEARS

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* JUNE 15, 1969, *that I last saw the deceased alive on* JUNE 15, 1969, *and that death occurred at* 11:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 4/29 P Rawlins (Degree or title)
23b. ADDRESS Emmett Idaho
23c. DATE SIGNED June 17 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE June 18, 1969
24c. NAME OF CEMETERY OR CREMATORY Sweet-Montour
24d. LOCATION (City, town, or county) (State) Sweet, Idaho

DATE REC'D BY LOCAL REG. June 18, 1969
REGISTRAR'S SIGNATURE Jean A. Beatty
25. EMBALMER Walter F. Potter
LICENSE NO. E445

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2805
Local Reg. No. 3154
Reg. Dist. No. 420

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wendell Manor 339

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
d. STREET ADDRESS (If rural, give location) 500 N. 18th E.

3. NAME OF DECEASED (Type or Print)
a. (First) MATILDA
b. (Middle)
c. (Last) PETERSON

4. DATE OF DEATH (Month) (Day) (Year) June 14, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 3, 1877
9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Dunkerton, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Schuler — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Diana — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 459-05-3323B
17. INFORMANT'S OWN SIGNATURE Russell S Peterson — ADDRESS —

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4122

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive cardiovascular dis. — 10 years
DUE TO (c) Deafness, cataracts, old age

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/27/, 19 68, *to* 6/14/, 19 69, *that I last saw the deceased alive on* 6/9/, 19 69, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 240 Harold F. Holsinger (Degree or title) MD
23b. ADDRESS Wendell, Idaho
23c. DATE SIGNED 6/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 15, 1969
24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery
24d. LOCATION (City, town, or county) Mountain Home, (State) Idaho

DATE REC'D BY LOCAL REG. 5-July-1969
REGISTRAR'S SIGNATURE Eddie G Leach
25. EMBALMER H Vert Humphreys — LICENSE NO. E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 20 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
JUN 20 1969
Bureau of Vital Statistics

State File No. 2806
Local Reg. No. 3149
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
c. LENGTH OF STAY (In this place) 10 days 210
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gooding Co. Mem. Hospital 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 442 Montana St.

3. NAME OF DECEASED (Type or Print)
a. (First) Charles
b. (Middle) Fredrick
c. (Last) Adamson

4. DATE OF DEATH (Month) (Day) (Year) June 15, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Sept. 24, 1893
9. AGE (In years last birthday) 75
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Store Owner 26
10b. KIND OF BUSINESS OR INDUSTRY & Operator
11. BIRTHPLACE (State or foreign country) Genessee, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Christian Adamson
BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Anna Jorgensen
BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes
(If yes, give war or dates of service) WW 1 3
16. SOCIAL SECURITY NO. 518-36-9274-A
17. INFORMANT'S OWN SIGNATURE X Ctef C Adamson
ADDRESS Gooding, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE — (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 Jun, 1969, *to* 15 Jun, 1969, *that I last saw the deceased alive on* 15 Jun, 1969, *and that death occurred at* 2 46 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 240 [signature] (Degree or title)
23b. ADDRESS Gooding, Idaho
23c. DATE SIGNED 17 Jun 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 18-June-69
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) (State) Gooding-Gooding Co., Idaho

DATE REC'D BY LOCAL REG. 18-June-1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER [signature]
LICENSE NO. E-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 2 3 1969

JUL 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Klingler

Certificate of Death

STATE OF IDAHO

State File No. 2807
Local Reg. No. 3150
Reg. Dist. No. 420

BIRTH NO.

RECEIVED JUN 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 24 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding c. LENGTH OF STAY (In this place) 6-mos. 26
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gooding Co. Mem. Hosp. OPD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gooding 24 C
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 1020 Nevada St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Reuben	M	Woody	June 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Widowed 2	Oct. 5, 1882	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29	Farming	Elko, Nevada	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Woody	Georgia	Katharine Wittel	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	------	519-40-6393-A	Pearl W. Fredericksen	Gooding, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Mellitus
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1, 1968, 19__, to June 21, 19 69, *that I last saw the deceased alive on* June 20, 19 69 *and that death occurred at* 5:35 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
285 Marvin O. Klingler MD	Gooding, Idaho	June 21, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-23-1969	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
23-June-69	Eddie D. Leach	Fred J. Nelson	E-504

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUN 30 1969 Bureau of Vital Statistics

State File No. 2808
Local Reg. No. 3151
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
LENGTH OF STAY (In this place): 7 hrs 407
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding County Mem. Hosp 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 317 Montana St.

3. NAME OF DECEASED (Type or Print)
a. (First): Clifford
b. (Middle): Lon
c. (Last): McNiel

4. DATE OF DEATH (Month) (Day) (Year): June 24, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Aug. 23, 1895
9. AGE (In years last birthday): 74
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad worker & Farming 10
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Green Forest, Ark.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin McNiel
BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Lidia Fanning
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---------
16. SOCIAL SECURITY NO.: 519-01-3235-A
17. INFORMANT'S OWN SIGNATURE: Thompson Chapel Records
ADDRESS: Gooding, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4411

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Aneurysm of Thoracid Aorta
INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis, generalized.
DUE TO (c): Mild hypertension.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* June 24, 1969, 19__, *that I last saw the deceased alive on* June 24, 1969, *and that death occurred at* 3:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Marion [signature] 285 (Degree or title) 1
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: 6-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 28, 1969
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: 27-June-69
REGISTRAR'S SIGNATURE: Eddie [signature]
25. EMBALMER: Fred J. Nelson
LICENSE NO.: E-504

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 2809
Local Reg. No. 3152
Reg. Dist. No. 420

BIRTH NO.

RECEIVED JUN 30 1969 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH

a. COUNTY Gooding 240

b. CITY OR TOWN Gooding (Rural)

c. LENGTH OF STAY (in this place) 60 yrs

d. FULL NAME OF HOSPITAL OR INSTITUTION 4 mi. W 1 mi So. Gooding

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY Jerome 270

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)

d. STREET ADDRESS (If rural, give location) Rt. 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	FRANK	K.	MOBLEY	June 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Jan. 18, 1906	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Bloomington, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ed Mobley	no record	Elsie Clelland	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 12 7963	Wilma Mobley	Rt. 2, Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 2 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) previous infarct

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 24 Jun, 1969, *to* 24 Jun, 1969, *that I last saw the deceased alive on* 24 Jun, 1969, *and that death occurred at* 11:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard E. Williams MD	Gooding Idaho	26 Jun 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 27, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
27 - June - 69	Zoddie D. Leach	W. L. Hove	E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2810
Local Reg. No. 315
Reg. Dist. No. 420

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gooding 240 — JUL 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
c. LENGTH OF STAY (in this place): Since 63/65
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
d. STREET ADDRESS (If rural, give location): 473 East Ave B

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HENRY	JOHN	SUFFA	June 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Feb. 23, 1881	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic Thresher 04	Farm	Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Suffa	Germany	Barbara Cree	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-01-5515	Ray Suffa	Wendell, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia	5 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Generalized arteriosclerosis	15 yrs.
DUE TO (c)	Senility	10 yrs.
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

4409

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3/29/50, 1950, *to* 6/25/, 19 69 *that I last saw the deceased alive on* 6-22, 1969, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold G Holsinger MD 240	Wendell, Idaho	6/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-28-69	Wendell Cemetery	Wendell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
5-July-1969	Eddie D Leach	Joe B. Leeper Joe B. Leeper	E-530

FIRM NAME: Leeper Mortuary Wendell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

69-5984

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2811
Local Reg. No. 3933
Reg. Dist. No. 420

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY Gooding 240 JUL 8 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding Bureau of Vital Statistics c. LENGTH OF STAY (In this place) 13 hrs. 443	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glennsferry
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gooding Co. Mem. Hospital 090	d. STREET ADDRESS (If rural, give location) P.O. Box 604

3. NAME OF DECEASED (Type or Print)	a. (First) Scott	b. (Middle) Lee	c. (Last) Pagac	4. DATE OF DEATH (Month) (Day) (Year)	June 27, 1969	
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	White	Never married	June 26, 1969	Infant		13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02	10b. KIND OF BUSINESS OR INDUSTRY -------	11. BIRTHPLACE (State or foreign country) Gooding, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Pagac	BIRTHPLACE Buhl, Idaho	14. MOTHER'S MAIDEN NAME Selma Emerson	BIRTHPLACE Gooding, Idaho			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ----------	16. SOCIAL SECURITY NO. none	17. INFORMANT'S OWN SIGNATURE George J. Pagac	ADDRESS Glennsferry, Ida.			

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7769

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 13 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) prematurity — 13 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 June, 1969, *to* 27 Jun, 1969, *that I last saw the deceased alive on* 27 Jun, 1969, *and that death occurred at* 5:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
	Gooding Idaho	30 Jun 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	30-June-69	Elmwood Cemetery	Gooding,	Idaho
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
30-JUNE-1969	Eddie D. Leach	Eddie D. Leach	E-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2812
Local Reg. No. 3156
Reg. Dist. No. 420

BIRTH NO.

RECEIVED JUL 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
c. LENGTH OF STAY (In this place) one
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)
d. STREET ADDRESS (If rural, give location) Bacon Ranch

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	J.	REASCH	June 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	Jan. 9, 1902	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Laborer 04	Agriculture	Rusdott, Russia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joe Reasch	Russia	Elizabeth Wolfe	Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-36-7022	X B. E. Reasch	Yakima, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4123 art. sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) art sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-14-66, 19 66 *to* 6-27-, 1969, *that I last saw the deceased alive on* 6-26-, 19 69, *and that death occurred at* 6:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
457 Maurice E. Leheel MD	Wendell, Idaho 83355	7-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 1, 1969	Jerome Cemetery	Jerome Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-July-69	Eddie D. Leach	W. L. Hove	E-498

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2813
Local Reg. No. 12
Reg. Dist. No. 242

BIRTH NO.

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN: Cottonwood
c. LENGTH OF STAY (in this place): 3 yrs 10 3
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Mary's Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN: Keuterville
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Caroline; b. (Middle); c. (Last) Uptmor

4. DATE OF DEATH: (Month) May (Day) 15 (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Nov 10 1885

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Effingham, Illinois

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Henry Luchtefeld
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Emma Donsbach
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 42 3171

17. INFORMANT'S OWN SIGNATURE: Edward Uptmor
ADDRESS: Keuterville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage-Hemaplegia — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 15 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Cholecystitis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1930, 19__, *to* 1969, 19__, *that I last saw the deceased alive on* May 14, 1969, *and that death occurred at* 2:12 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wesley J. Orr M.D.
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: May 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May 17 1969
24c. NAME OF CEMETERY OR CREMATORY: Keuterville
24d. LOCATION (City, town, or county) (State): Keuterville, Idaho

DATE REC'D BY LOCAL REG.: May 17, 1969
REGISTRAR'S SIGNATURE: Wesley J. Orr M.D.
25. EMBALMER: Clifford Uhlorn
LICENSE NO.: E421
FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

State File No. 2814
Local Reg. No. 40
Reg. Dist. No. 240

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUN 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (In this place): 2 yrs 102
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho County Nursing Home 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Idaho County Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First): MINNIE
b. (Middle):
c. (Last): Mc MEEKEN

4. DATE OF DEATH (Month) (Day) (Year): June 4, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 31, 1881
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Powell — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Sarah Arenspeiger — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 16 9081
17. INFORMANT'S OWN SIGNATURE: Mrs Fern C Goin — ADDRESS: Craigmont, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5621 Large Bowel obstruction — INTERVAL BETWEEN ONSET AND DEATH: Few days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) diverticulitis — Sev. years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerotic heart dis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1967, *to* 4 June, 1969, *that I last saw the deceased alive on* 3 June, 1969, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Donald Holtman M.D. 487 (Degree or title)
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 6 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/9/69
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: June 12, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: 433
FIRM NAME: hansen funeral home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2815
Local Reg. No. 191
Reg. Dist. No. 244

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 250 JUN 13 1969
b. CITY OR TOWN Kooskia
c. LENGTH OF STAY (in this place) 45 yrs. 1/5
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kooskia
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Sid b. (Middle) c. (Last) Poppe

4. DATE OF DEATH (Month) (Day) (Year) June 4, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Feb. 10, 1896

9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forestry Work

10b. KIND OF BUSINESS OR INDUSTRY U.S. Forest Service

11. BIRTHPLACE (State or foreign country) Miles City Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles H. Poppe BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unk. BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO. 518-24-2915

17. INFORMANT'S OWN SIGNATURE George Ball ADDRESS Kooskia

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 955.X

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Suicide

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) At Home

21c. (CITY, TOWN, OR TOWNSHIP) Kooskia (COUNTY) Idaho (STATE) Idaho

21d. TIME OF INJURY (Month) 6 (Day) 4 (Year) 1969 (Hour) 4:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Self inflicted pistol shot

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE R. Smith 588 (Degree or title) Justice of Peace

23b. ADDRESS Kooskia, Idaho

23c. DATE SIGNED 6/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 7, 1969

24c. NAME OF CEMETERY OR CREMATORY Pine Grove Cem.

24d. LOCATION (City, town, or county) Kooskia (State) Idaho Idaho

DATE REC'D BY LOCAL REG. 6/5/69

REGISTRAR'S SIGNATURE Claude Tenary

25. EMBALMER Glen R. Hansen LICENSE NO. E433

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUN 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

3 Copies

RECEIVED JUL 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2816
Local Reg. No. 13
Reg. Dist. No. 242

BIRTH NO.

1. PLACE OF DEATH 250
a. COUNTY Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cottonwood
c. LENGTH OF STAY (in this place) 3 yrs 103
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) San Francisco
d. STREET ADDRESS (If rural, give location) 2001 California St.

3. NAME OF DECEASED (Type or Print) a. (First) Blanche b. (Middle) W. c. (Last) Guerin

4. DATE OF DEATH (Month) June (Day) 7 (Year) 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Aug 11 1884
9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME George M. Warren BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Jo Anna D'Arcy BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Mark C. Guerin ADDRESS Grangeville

18. CAUSE OF DEATH 4379
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility — INTERVAL BETWEEN ONSET AND DEATH 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerotic brain disease — 3 yrs

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* April, 1966, *to* June 7, 1969, *that I last saw the deceased alive on* June 6, 1969, *and that death occurred at* 2:20 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 444 (Degree or title) MD
23b. ADDRESS Grangeville Idaho
23c. DATE SIGNED 11 June 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE June 14, 1969
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Evanston, Illinois

DATE REC'D BY LOCAL REG. June 11, 1969
REGISTRAR'S SIGNATURE Wesley F. Orr MD by TN
25. EMBALMER [signature] Chlorn
LICENSE NO. E 421
FIRM NAME: Chlorn Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JUL 15 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2817
Local Reg. No. 14
Reg. Dist. No. 242

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (in this place): 0-0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): JERRY
b. (Middle): NEIL
c. (Last): ALBERS

4. DATE OF DEATH (Month) (Day) (Year): 11 June 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 15 March 1960
9. AGE (In years last birthday): 9 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (State or foreign country): Orofino, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Raymond O. Albers — BIRTHPLACE: Russell, Idaho
14. MOTHER'S MAIDEN NAME: Margaret Braun — BIRTHPLACE: Russell, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Raymond Albers — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebellar Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: One hour from Birth

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Angioma of cerebellum
DUE TO (c) Congenital

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 12:05 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm H Greenwood 189 MD 1
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 6-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal/Burial
24b. DATE: Burial 13 Jun 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, NezPerce Co., Ida.

DATE REC'D BY LOCAL REG.: June 13, 1969
REGISTRAR'S SIGNATURE: Wesley F. Orr MD
25. EMBALMER: W. E. Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2818
Local Reg. No. 42
Reg. Dist. No. 240

69-6006
BIRTH NO.

RECEIVED
JUN 30 1969
Bureau of Vital Statistics
STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Idaho 25
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hosp. 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Kittitas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Thorp
d. STREET ADDRESS (If rural, give location): Box 107

3. NAME OF DECEASED (Type or Print): a. (First) TERESSA b. (Middle) ANN c. (Last) CRAWFORD

4. DATE OF DEATH (Month) (Day) (Year): June 18, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Child

8. DATE OF BIRTH: June 17, 1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours 13 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Grangeville, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Crawford — BIRTHPLACE: Leon, Iowa

14. MOTHER'S MAIDEN NAME: Christian Craig — BIRTHPLACE: Ellensberg, Wash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X John Robert Crawford — ADDRESS: Thorp, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7777

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity (32 weeks gestation) — INTERVAL BETWEEN ONSET AND DEATH: 13 Hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/17, 1969 *to* 6/18, 1969, *that I last saw the deceased alive on* 6/18, 1969 *and that death occurred at* 12:50 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wm Hamilton MD 373 (Degree or title)

23b. ADDRESS: Grangeville, Id

23c. DATE SIGNED: 6/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: June 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Prairieview

24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: June 26, 1969

REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: Robert R Hansen — LICENSE NO.: E 453

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2819
Local Reg. No. 41
Reg. Dist. No. 240

Certificate of Death

RECEIVED
JUN 27 1969
Bureau of Vital Statistics
Highway 13

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville-11 mi. east
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 13 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Grangeville Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): EDWARD
b. (Middle): WINSTON
c. (Last): ETTER

4. DATE OF DEATH (Month) (Day) (Year): 6 - 22 - 69

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 2
8. DATE OF BIRTH: November 6, 1945
9. AGE (In years last birthday): 23 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: auto repair
11. BIRTHPLACE (State or foreign country): Lewistown Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Kenneith I Etter — BIRTHPLACE: Washington
14. MOTHER'S MAIDEN NAME: Eilene Kavanaugh — BIRTHPLACE: Lewistown Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes 1 — (If yes, give war or dates of service): Veitnam 01
16. SOCIAL SECURITY NO.: 519-52-3083
17. INFORMANT'S OWN SIGNATURE: X C. H. Ketchum Jr. — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushing Injuries

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto Accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 13 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): East og Grangeville Idaho 250 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 22 69 4A m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Vehicle Left Highway Rolled several Times

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] IDAHO COUNTY CORONER 385 4
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 6-25-69
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville Idaho

DATE REC'D BY LOCAL REG.: June 24, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R. Hansen — Robert R Hansen
LICENSE NO.: E 43
FIRM NAME: Hansen funeral home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2820
Local Reg. No. 42
Reg. Dist. No. 240

BIRTH NO.

RECEIVED
JUN 30 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lowell rural
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Highway 12, 37 miles E. of Lowel

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY San Mateo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Colma
d. STREET ADDRESS (If rural, give location) 376 87th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Honey	Veronica	Wilkerson	June 25, 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	White	married S	July 24, 1914	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper 19	Various	Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew J. Roberts	unknown	Anna M. unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	00	418-24-8964	[signature]	Daly City, Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		auto accident

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___ *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Transportation	6/30/69	Cypress Lawn Memorial	Colma California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 26 1969	Irma Cone	Robert R Hansen	E 433

FIRM NAME: Hansen funeral home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2821
Local Reg. No. 44
Reg. Dist. No. 240

BIRTH NO.

RECEIVED JUL 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 250 Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Riggins
c. LENGTH OF STAY (In this place) Hrs 4400
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Allison Creek Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Riggins
d. STREET ADDRESS (If rural, give location) Riggins, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) JACKIE
b. (Middle) MARVIN
c. (Last) BURT

4. DATE OF DEATH (Month) (Day) (Year) June 24, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH June 30, 1938

9. AGE (In years last birthday) 30
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY Various

11. BIRTHPLACE (State or foreign country) Council, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Claude E Burt
BIRTHPLACE Chester, Idaho

14. MOTHER'S MAIDEN NAME Alice Clark
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) U.S. Navy 0

16. SOCIAL SECURITY NO. 518 38 5690

17. INFORMANT'S OWN SIGNATURE X Claude E. Burt
ADDRESS Hermiston Ore

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Death Due to Natural Cause — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Weak Heart Congested organs
DUE TO (c) etc Possible Exposure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION See Above

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Riggins Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 583 IDAHO COUNTY CORONER

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6/27/69

24c. NAME OF CEMETERY OR CREMATORY Riggins

24d. LOCATION (City, town, or county) Riggins, Idaho (State)

DATE REC'D BY LOCAL REG. July 7 1969

REGISTRAR'S SIGNATURE Irma Cone

25. EMBALMER Robert R Hansen Robert R Hansen

LICENSE NO. E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 2 0 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2822
Local Reg. No. 13
Reg. Dist. No. 640

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260 JUL 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Rigby Bureau of Vit.
c. LENGTH OF STAY (in this place): 4 yrs. 04
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carson Nursing Home 097

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Oneida 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad
d. STREET ADDRESS (If rural, give location): 361 North Main St.

3. NAME OF DECEASED (Type or Print)
a. (First): GOTTLIEB
b. (Middle): B.(only)
c. (Last): SCHWARTZ

4. DATE OF DEATH (Month) (Day) (Year): June 10, 1969

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: July 13, 1884
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: agriculture
11. BIRTHPLACE (State or foreign country): Helterfinger, Bern, Switzerland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Gottlieb Schwartz
BIRTHPLACE: Schangnau, Bern, Switzerland
14. MOTHER'S MAIDEN NAME: Rosina Bieri
BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-42-9807
17. INFORMANT'S OWN SIGNATURE: Darrel G. Swartz
ADDRESS: Malad, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Thrombosis Rt. Femoral artery with gangrenous changes Rt Reg.
INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Arteriosclerotic Heart Disease
years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 June, 1965, *to* 10 June, 1969, *that I last saw the deceased alive on* 9 June, 1969, *and that death occurred at* 3:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Asael Hall, 522 M.D. 1
23b. ADDRESS: Rigby, Idaho.
23c. DATE SIGNED: 6/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: June 10, 1969
24c. NAME OF CEMETERY OR CREMATORY: Malad City Cemetery
24d. LOCATION (City, town, or county) (State): Malad City, Idaho

DATE REC'D BY LOCAL REG.: 6/10/69
REGISTRAR'S SIGNATURE: Mrs A B Eckersell
25. EMBALMER: Raford G. Benson
LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: BENSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2823
Local Reg. No. 1215
Reg. Dist. No. 440

RECEIVED JUN 11 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place): 4 mos. 2 dys
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jerome Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier 83254
d. STREET ADDRESS (If rural, give location): 439 No. 9th st.

3. NAME OF DECEASED (Type or Print): a. (First) Abraham b. (Middle) Charles c. (Last) VanOrman

4. DATE OF DEATH (Month) (Day) (Year): June 1 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: April 3, 1882

9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & U.P.Railroad

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Abraham J. VanOrman — BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Margaret Hunter — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 712-07-0351

17. INFORMANT'S OWN SIGNATURE: Lyle C VanOrman — ADDRESS: Jerome Idaho

887X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Intertrochanteric fracture of

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): left femur, followed by

DUE TO (c): bronchopneumonia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Hypertension; senile cystitis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE? (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hospital 13

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Jerome, Jerome 270, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): May 29 1969 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Patient tried to get out of bed and fell on floor.

22. *I hereby certify that I attended the deceased from* Mar. 7, 1969, *to* June 1, 1969, *that I last saw the deceased alive on* June 1, 1969, *and that death occurred at* 1:55P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. Corlyle Buell (Degree or title): MD

23b. ADDRESS: Jerome, Idaho

23c. DATE SIGNED: June 5, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: June 1, 1969

24c. NAME OF CEMETERY OR CREMATORY: Montpelier Cemetery

24d. LOCATION (City, town, or county) (State): Montpelier Idaho

DATE REC'D BY LOCAL REG.: June 9, 1969

REGISTRAR'S SIGNATURE: Louella M. Schurer

25. EMBALMER: W. L. Hess

LICENSE NO.: E.431

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2824
Local Reg. No. 1274
Reg. Dist. No. 446

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
JUN 11 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give STATE): Jerome
c. LENGTH OF STAY (in this place): 0-40
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 1089

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 708 East Ave. "B"

3. NAME OF DECEASED (Type or Print): a. (First) DOYLE; b. (Middle) ROBERT; c. (Last) HILLIER

4. DATE OF DEATH (Month) (Day) (Year): June 3, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 5

8. DATE OF BIRTH: July 24, 1931

9. AGE (In years last birthday): 37
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plant Mgr. 76

10b. KIND OF BUSINESS OR INDUSTRY: Potato Processing

11. BIRTHPLACE (State or foreign country): Cavalier, North Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ralph Hillier
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Myrtle Fitzsimonds
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 501-28-3057

17. INFORMANT'S OWN SIGNATURE: Mrs Margaret Hillier
ADDRESS: Jerome, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gunshot wound of left head, [illegible] — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Depression — 1 year
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Acute alcoholic ingestion

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Self inflicted
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Jerome Jerome 270 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 3, 1969 10:30 AM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Unknown

22. *I hereby certify that I attended the deceased from* January 1, 1968, *to* June 3, 1969, *that I last saw the deceased alive on* June 3, 19 69, *and that death occurred at* 1:12P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Jon D. Wilmoth, M.D. (Degree or title): M.D.
23b. ADDRESS: 316 E. Main St. Jerome Idaho
23c. DATE SIGNED: June 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome Idaho

DATE REC'D BY LOCAL REG.: June 9 1969
REGISTRAR'S SIGNATURE: Louella M Scherer

25. EMBALMER: Glen G. Giron
LICENSE NO.: E-498

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2825
Local Reg. No. 1218
Reg. Dist. No. 440

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUN 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Nursing Home 257

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 328 2nd. Ave. East

3. NAME OF DECEASED (Type or Print)
a. (First) HATTIE
b. (Middle) MAE
c. (Last) BOBBITT

4. DATE OF DEATH (Month) (Day) (Year) June 17, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct. 13, 1889
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Stella, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William F. Stoltz — BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Mary Ulmer — BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-44-1200
17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS Jerome, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1829

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Uterus — INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Pagets disease Secondary anemia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 2, 1969, *to* June 17, 1969, *that I last saw the deceased alive on* June 17, 1969, *and that death occurred at* 1:25P. *m., from the causes and on the date stated above.*

23a. SIGNATURE Reuben C. Matson MD (Degree or title) 230
23b. ADDRESS Jerome Ida
23c. DATE SIGNED 6-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 20, 1969
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. June 23 1969
REGISTRAR'S SIGNATURE Louella M. Sobirer
25. EMBALMER Glen G. Giren
LICENSE NO. E-498

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2826
Local Reg. No. 1219
Reg. Dist. No. 440

BIRTH NO.

JUN 26 1969

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Jerome 270

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338

c. LENGTH OF STAY (in this place): 10 days 3/4

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Lincoln 520

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richfield 83349

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CHRISTOPHER	OTHO	CHATFIELD	June 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	Nov. 6, 1879	89	7	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired farmer 04	Farming	Polk Co., Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Chatfield	England	Mary Maria Crandall	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	552-36-7387-A	Mrs. O. T. Chatfield	c Richfield, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4310

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage, Left — INTERVAL BETWEEN ONSET AND DEATH: June 9'69

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Senility & Hypertension — Several yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. 0

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1963, 19___, *to* 6/19, 1969, *that I last saw the deceased alive on* 6/19/69, 19___, *and that death occurred at* 2:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Carlyle Ruail MD	Jerome Idaho	June 23'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-23-1969	Richfield Cemetery	Richfield, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 24 1969	Lawella M. Schurr	Frances M Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 27 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2827
Local Reg. No. 1221
Reg. Dist. No. 440

RECEIVED JUN 27 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 360 3rd street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton 83335
d. STREET ADDRESS (If rural, give location): 360 3rd Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Henry	Edward	Gundelfinger	June 28th, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	January 27th 1885	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bank President
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pittsburg, Pa.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Christopher Gundelfinger — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Christine Lueck — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 519-14-7799
17. INFORMANT'S OWN SIGNATURE: Mrs. H.E. Gundelfinger — ADDRESS: Hazelton,

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis — several years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 16, 1969, *to* June 17, 1969, *that I last saw the deceased alive on* June 17, 1969, *and that death occurred at* 4:55 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Jon D. Wilmoth, M.D. (Degree or title)	Jerome, Idaho	6.23.69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6.24.69	Sunset Memorial Park Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 25 1969	Louella M. Deherrera	Edgar Robertson	E-507

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 8 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2828
Local Reg. No. 1220
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 26 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (rural)
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 13 mi. No. East of Jerome

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 116 6th. Ave. East

3. NAME OF DECEASED (Type or Print)
a. (First): PETE
b. (Middle):
c. (Last): ETCHART

4. DATE OF DEATH (Month) June (Day) 22 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: Spanish
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: May 1, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Aria, Spain
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Pete Etchart — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Gracianna Arrossgaray — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 42 1663
17. INFORMANT'S OWN SIGNATURE: X Antonia Llona — ADDRESS: Gooding, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning —

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) either cerebral hemorrhage

DUE TO (c) or coronary occlusion

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: — Minutes only

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Fell in shallow canal.

22. *I hereby certify that I attended the deceased from* —, 19__, *to* —, 19__, *that I last saw the deceased alive on* —, 19__, *and that death occurred at* ? *m., from the causes and on the date stated above.*

23a. SIGNATURE: A. M. Scherer, M.D. (Degree or title) Coroner 4
23b. ADDRESS: Jerome
23c. DATE SIGNED: 24 Jun 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 26, 1969
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: June 24 1969
REGISTRAR'S SIGNATURE: Lovella M. Scherer
25. EMBALMER: Glen G. Siren
LICENSE NO.: E-498

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2829
Local Reg. No. 1223
Reg. Dist. No. 440

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
c. LENGTH OF [illegible] (in this place) 200
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hosp 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) Route#2

3. NAME OF DECEASED (Type or Print)
a. (First) DELLA
b. (Middle) P.
c. (Last) OLSON

4. DATE OF DEATH (Month) (Day) (Year) June 24, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH August 9,1892
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cave City, Kentucky
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John C. Padgett — BIRTHPLACE Glasgow, Kentucky
14. MOTHER'S MAIDEN NAME Sarah Payne — BIRTHPLACE Monroe Co. Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 07 9771
17. INFORMANT'S OWN SIGNATURE Richard D. Olson — ADDRESS 609 High Modesto Cal.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5741

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: One week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cholecystitis + cholelithiasis + Choledocholithiasis — Several months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION June 16, 1969
19b. MAJOR FINDINGS OF OPERATION Gallstones
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/12/69, 19__, *to* 6/24/69, 19__, *that I last saw the deceased alive on* 6/24/69, 19__, *and that death occurred at* 6:45P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) W. Carlyle 477 Fusil, MD
23b. ADDRESS Jerome, Idaho
23c. DATE SIGNED 6.26.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6.28.69
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State) TwinFalls, Idaho

DATE REC'D BY LOCAL REG. June 30, 1969
REGISTRAR'S SIGNATURE Louella M. Schurer
25. EMBALMER Jerry D. Holman — LICENSE NO. E-516
FIRM NAME: White Mortuary TwinFalls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 18 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 7 1969 Bureau of Vital Statistics

State File No. 2830
Local Reg. No. 1225
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
(LENGTH OF STAY (In this place) 1-day 30/
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Benedict's Hospital 089

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerman 83332
d. STREET ADDRESS (If rural, give location) ------

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Emma Emily	Alice	Arterburn	June 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	Jan. 1, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Terre Haute, Ind.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Bateman Huffman	Indiana	Flora B. Soloman	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-----	518-12-6268-A	X Norben E. Arterburn	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4121

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) cor. sclerotic heart disease

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) chr. nephritis
DUE TO (c) hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-15- , 19 61 , *to* 6-26-69 , 19 , *that I last saw the deceased alive on* 6-26-69 , 19 , *and that death occurred at* 8:15 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
457 Maurice E. Schuetz MD	Wendell, Idaho 83355	6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	30-June-69	Hagerman Cemetery	Hagerman, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 1, 1969	Louella M. Scherer	Eddie G. Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 2831
Local Reg. No. 1224
Reg. Dist. No. 440

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270 JUL 1 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 000
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 707 East Ave. "B" 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 707 East Ave. "B"

3. NAME OF DECEASED (Type or Print)
a. (First): RUTH
b. (Middle): ADA
c. (Last): HAWES

4. DATE OF DEATH (Month) (Day) (Year): June 26, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 10, 1911
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Virginia City, Nevada
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry E. Winter — BIRTHPLACE: Nevada
14. MOTHER'S MAIDEN NAME: Mary G. McCormick — BIRTHPLACE: Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-26-9470
17. INFORMANT'S OWN SIGNATURE: X John M. Hawes Jr. — ADDRESS: Jerome, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Head injury from fall — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Mild congestive heart failure 2 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Own home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Jerome 270 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Jun 26 69 Noon
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Fell off ladder

22. *I hereby certify that I attended the deceased from* none *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* about noon *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. M. Reber, M.D. Coroner
23b. ADDRESS: Jerome
23c. DATE SIGNED: 30 Jun 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: June 30 1969
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 18 1969 Bureau of Vital Statistics

State File No. 2832
Local Reg. No. 189
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Kootenai 287	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai 287
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene — c. LENGTH OF STAY (In this place): 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 110	d. STREET ADDRESS (If rural, give location): Rt. #2 Box 79

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ruby	M.	Clark	June 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	Sept. 4, 1904	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Carthage, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Chas. R. Cobough	Iowa	Janice Lawson	Okla.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	521-28-0531	x Dave F. Clark	Wallace, Idaho

5400

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Rupture of the appendix with massive acute peritonitis internal approx. 48 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Arteriosclerotic cardiovascular disease & Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
097 C. J. Cederblom, M.D. 1		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	6-7-1969	Restlawn Memorial Pk.	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 16, 1969	Lorraine K. Brush	N. F. Riphinger Jr.	E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUN 18 1969 Bureau of Vital Statistics

State File No. 2833
Local Reg. No. 161
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. LENGTH OF STAY (In this place) 40 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Own home in POst Falls 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Howard	Martin	Sweitzer	June	3,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Married 3	5/11/02	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Constuction	Penn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Sweitzer	Germany	Mary Conoway	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-03-2917	Agnes Sweitzer	Post Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7960

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cause ill defined — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. Coroner	Coeur d'alene Idaho	6-6-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/7/69	Evergreen	Post Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 6, 1969	Lorraine K. Brush	Fred Noland	E-493

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 16 1970

MAR 25 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2834
Local Reg. No. 163
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUN 24 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Kootenai 28C

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene

c. LENGTH OF STAY (in this district): 6 months 206

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2514 N. 7th, Pinewood Manor 88

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bonner 080

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Priest River

d. STREET ADDRESS (If rural, give location): Church Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Elizabeth	Bridgett	Byers	June 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	July 17, 1888	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	Own Home	Minnesota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mike Smithwick	Ireland	Mary Condon	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Unknown	Mike Byers	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction 4289

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 19 [illegible], *to* June, 19 69, *that I last saw the deceased alive on* June 5, 19 69, *and that death occurred at* 2:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Coeur d'Alene Id	6/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-burial	June 7, 1969	Evergreen Cemetery	Priest River, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 17, 1969	Lorraine K. Brush	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2835
Local Reg. No. 180
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 00y 11o
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 320 Military Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lucretia	G.	Knudson	June	5,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	March 19, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife c/	Own Home	Freeport, Ill.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Snyder	Indiana	Mary Jane Smith	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no / none	518-16-9900	By Robert H Knudson	Spokane, Wn

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Embolism 5 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
(b) Diverticulitis with
DUE TO (c) perforation

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hepatic dysfunction from viral disease

INTERVAL BETWEEN ONSET AND DEATH

562.1

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 1960, to _____, 1969, that I last saw the deceased alive on June 5, 1969 and that death occurred at 9 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm Templeton MD	Coeur d'Alene, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-7-1969	Forest Cemetery	Coeur d'Alene, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 1, 1969	Lorraine K. Brush	Bill Neff	E-439

FIRM NAME English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 1 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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51-12258

Certificate of Death

RECEIVED STATE OF IDAHO

JUN 24 1969

Bureau of Vital Statistics

State File No. 2836
Local Reg. No. 168
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene LENGTH OF STAY in this place 4yrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp.	d. STREET ADDRESS (If rural, give location) 1219 St. Maries

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)	
ROYLEE	L.	SMITH	June 8,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	9/6/1952	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		Weiser, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Vivian Smith	Idaho	Audrey Amos	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	None	V.D. Smith -	Coeur d'Alene, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

955X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gunshot Wound Brain — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide	Home	Coeur d'Alene Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 8, 1969, *to* June 8, 1969, *that I last saw the deceased alive on* June 8, 1969 *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Coeur d'Alene Idaho	6-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/11/1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 20, 1969	Lorraine K. Brush	Fred H. Noland	E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED JUN 24 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2837
Local Reg. No. 165
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 280	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene c. LENGTH OF (In this place) 42 yrs. 142	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hayden Lake
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp. 110	d. STREET ADDRESS (If rural, give location) Rt. # 1

3. NAME OF DECEASED (Type or Print)	a. (First) WALTER	b. (Middle) F.	c. (Last) KRIDER	4. DATE OF DEATH (Month) (Day) (Year) June 11, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH 4/27/1883	9. AGE (In years last birthday) 86	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Worker 17	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) York, Penn	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Krider	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Spanish Amer.	16. SOCIAL SECURITY NO. 518-34-5237	17. INFORMANT'S OWN SIGNATURE Penelopy Krider -	ADDRESS Hayden Lk, Ida.		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Carcinoma prostate	2 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Congestive heart Failure	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-6, 1968, *to* June 11, 1969, *that I last saw the deceased alive on* 6-11, 1969 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 658 R.H. Englston (Degree or title) MD	23b. ADDRESS Hayden Lake Idaho	23c. DATE SIGNED 6-17-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/13/1969	24c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial	24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho
DATE REC'D BY LOCAL REG. June 18, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Fred H. Noland	LICENSE NO. E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended July 14, 1969

Certificate of Death
STATE OF IDAHO

State File No. 2838
Local Reg. No. 167
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 ✓
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Sunset Terrace 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Montana 27 b. COUNTY: Custer
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Miles City
d. STREET ADDRESS (If rural, give location): 219 N. Stacy

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Leonard	Louis	Riebe	June	12,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 5	June 7, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railroad 10	Machinist	Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Louis Frederick Riebe	Germany	Kate Borger	Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
-----	-----	707-14-1139	Herschell J. Riebe	Coeur d'Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Vascular Accident	1 hour
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)	Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 10, 19 69, *to* June 12, 19 69, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. M. Gumprecht, M.D.	302 W. 5th	13 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 16, 1969	Miles City Cemetery	Miles City, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 16,1969	Lorraine K. Brush	Bill Duff	E 439

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: English Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
JUL 11 1969
Bureau of Vital Statistics

State of Idaho
County of Kootenai } ss.

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Leonard Lewis Riebe (Name on Original Certificate) who died (Was Born or Died) on June 12, 1969 (Date of Event)
in Coeur d'Alene, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name of Deceased	Leonard Lewis Riebe	Leonard Louis Riebe
Date of Birth, Soc.Sec.No.	June 6, 1886, not given	June 7, 1886 , 707-14-1139
Father & Mothers Name	Lewis Riebe -unobtainable	Louis Frederick Riebe-Kate Borger
Date of Burial	June 14,1969	June 16, 1969

Subscribed and sworn to before me this 10th day of July, 19 69

Notary Public, residing at Coeur d'Alene, Ida

My commission expires 6-10-71

(Seal)

Signed Josephine Z. Riebe
(Signature of parent or attendant if correcting a birth record; or attendant, funeral director, informant if correcting a death record; or other credible person.)

.....
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Kootenai } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 10th day of July, 19 69

Notary Public, residing at Coeur d'Alene

My commission expires November 15, 1969

(Seal)

Signed Don C. English
(Signature of Any Credible Person)

1144 - 4th Cd'A Idaho
(Street Address, City, State)

FORM DH 60-155

7-7-69 AA

RECEIVED
JUL 11 1989
Bureau of Vital Statistics

NOTARY PUBLIC
STATE OF IDAHO

NOTARY PUBLIC
STATE OF IDAHO

Certificate of Death
STATE OF IDAHO

RECEIVED
JUN 24 1969
Bureau of Vital Statistics

State File No. _____
Local Reg. No. 167
Reg. Dist. No. 120

BIRTH NO. _____

1. PLACE OF DEATH a. COUNTY: Kootenai	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Montana b. COUNTY: Custer
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene c. LENGTH OF STAY (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Miles City
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace	d. STREET ADDRESS (If rural, give location): 219 N. Stacy

3. NAME OF DECEASED (Type or Print)	a. (First): Leonard	b. (Middle): Lewis	c. (Last): Riebe	4. DATE OF DEATH (Month) (Day) (Year): June 12, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: June 6, 1886	9. AGE (In years last birthday): 83 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad	10b. KIND OF BUSINESS OR INDUSTRY: Machinist	11. BIRTHPLACE (State or foreign country): Wisc.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Lewis Riebe	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Unobtainable	BIRTHPLACE: Holland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----- (If yes, give war or dates of service) ----------	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: X Herschell J. Riebe	ADDRESS: Ida. Coeur d'Alene	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral vascular — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): accident
DUE TO (c): arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 10, 1969, *to* June 12, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: D M Gumprecht M.D. (Degree or title)	23b. ADDRESS: 302 N 5th	23c. DATE SIGNED: 13 June 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: June 14, 1969	24c. NAME OF CEMETERY OR CREMATORY: Miles City Cemetery	24d. LOCATION (City, town, or county): Miles City (State): Montana
DATE REC'D BY LOCAL REG.: June 16, 1969	REGISTRAR'S SIGNATURE: Lorraine K. Brush	25. EMBALMER: Bill Duff Bill Duff	LICENSE NO.: E 439

FIRM NAME: English Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 1969

JUL 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 6 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 1 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 2839
Local Reg. No. 177
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUN 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) Pinewood Manor Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Frederica	Fitzer	Wood	June	12	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	W	Oct. 6, 1875	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable		Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-03-7076	Franco Howard	Coeur d'Alene Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebrovascular accident	2 wks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Anterioscleratic cardiovascular disease	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1964, 19____, *to* 6/13/69, 19____, *that I last saw the deceased alive on* 5/24/69, 19____, *and that death occurred at* 5:50p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Don Moseley, M.D.	421 Coeur d'Alene Coeur d'Alene, Idaho	6/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-16-1969	Forest Cemetery	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 18, 1969	Lorraine K. Breuch	Bill Duff	E-439

FIRM NAME English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 30 1999

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 2840
Local Reg. No. 169
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
JUN 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 280	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rathdrum
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Highway #10 000	d. STREET ADDRESS (If rural, give location) Box 305

3. NAME OF DECEASED (Type or Print)	a. (First) Thomas	b. (Middle) L.	c. (Last) Van Wormer	4. DATE OF DEATH (Month) (Day) (Year) June 13, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never /	8. DATE OF BIRTH March 22, 1947	9. AGE (In years last birthday) 22 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Northern Pacific R.R. 10	10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Cd'A, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leon VanWormer	BIRTHPLACE Wisc.	14. MOTHER'S MAIDEN NAME Ruth A. Sauer	BIRTHPLACE N. Dakota	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Army	16. SOCIAL SECURITY NO. 518-56-7869	17. INFORMANT'S OWN SIGNATURE Leon Van Wormer	ADDRESS Rathdrum Ida	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8129

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	accidental traumatism due	Immediate
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	to automobile accident	
DUE TO (c)	multiple crush injuries	"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) / accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Hiway 06	21c. (CITY, TOWN, OR TOWNSHIP) Highway 10.	(COUNTY) Kootenai 280 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 13, 1969 m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Car ran into rear of truck.	

22. *I hereby certify that I attended the deceased from* Did not *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 712	(Degree or title) Coroner	23b. ADDRESS Coeur d'Alene, Idaho	23c. DATE SIGNED 6/17/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial /	24b. DATE 6-19-1969	24c. NAME OF CEMETERY OR CREMATORY Pinegrove Cemetery	24d. LOCATION (City, town, or county) Rathdrum, (State) Ida.
DATE REC'D BY LOCAL REG. June 18, 1969	REGISTRAR'S SIGNATURE Lorraine K Brush	25. EMBALMER N. K. Rightinger Jr.	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d' Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 25 1969
AUG 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2841
Local Reg. No. 174
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 JUN 27 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 12 Days

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 28 b. COUNTY Spokane
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Newman Lake

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital
d. STREET ADDRESS (If rural, give location) Route #1 Box 208

3. NAME OF DECEASED (Type or Print) a. (First) LOYED b. (Middle) PHILMON c. (Last) BLANCHER

4. DATE OF DEATH (Month) June (Day) 15, (Year) 1969

5. SEX Male

6. COLOR OR RACE Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH 24/5/02

9. AGE (In years last birthday) 67 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY Several

11. BIRTHPLACE (State or foreign country) Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Faris Blancher, Sr. BIRTHPLACE Wisconsin

14. MOTHER'S MAIDEN NAME Emma Larsen BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Iona Calstro ADDRESS Newman Lake, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ASHD

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-27 19 69 *to* 6-15-69 19 *that I last saw the deceased alive on* 6-15-69 *and that death occurred at* 4:15 a.m. *the causes and on the date stated above.*

23a. SIGNATURE Glen M. Farnham (Degree or title) MD

23b. ADDRESS Hayden Lake, Idaho

23c. DATE SIGNED 6-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 21/6/69

24c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. June 25, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2842
Local Reg. No. 164
Reg. Dist. No. 126

RECEIVED JUN 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Route #1 Box 325 Hayden Lake
d. STREET ADDRESS (If rural, give location): Route #1 Box 325 Hayden Lake, Ida.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELLIS	B.	DUGGER	June 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	20/5/19	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	Ace Concrete	Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Willard Dugger	North Carolina	Florence Fields	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II	519-05-0762	Cleone Dugger	Route 1 Box 325 Hayden Lake, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 201X Hodkins disease — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: kidneys failure

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
8-11-67 m.		

22. I hereby certify that I attended the deceased from 8-11-67 19___, to 6-15-69 19___, that I last saw the deceased alive on 6-15-69, 19___, and that death occurred at 3:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John M. Parkham M.D.	Hayden Lake Idaho	6-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	19/6/69	Pines Cemetery	Opportunity, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 18, 1969	Lorraine K. Brunell	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 2 6 1969
JUL 1 1969
NOV 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

State File No. 2843
Local Reg. No. 188
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 28	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1037 N. 3rd St. Apt. #3	d. STREET ADDRESS (If rural, give location) 1037 N. 4th St. Apt. #3

3. NAME OF DECEASED (Type or Print)	a. (First) Philip	b. (Middle) L.	c. (Last) Westling	4. DATE OF DEATH (Month) (Day) (Year) June 15, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 5	8. DATE OF BIRTH Feb. 28, 1890	9. AGE (In years last birthday) 79 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. R. Conductor 10	10b. KIND OF BUSINESS OR INDUSTRY Milwawkee R.R.	11. BIRTHPLACE (State or foreign country) Princeton, Minn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Westling	BIRTHPLACE Sweden	14. MOTHER'S MAIDEN NAME Carrie (Unobtainable)	BIRTHPLACE Sweden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) W.W. I	16. SOCIAL SECURITY NO. 707-18-2804	17. INFORMANT'S OWN SIGNATURE Mildred A. Westling	ADDRESS Coeur d'Alene

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 15 minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 15, 1969, *to* June 15, 1969, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE C. E. Thompson 530	(Degree or title) MD	23b. ADDRESS Coeur d'Alene Idaho	23c. DATE SIGNED June 13, 1969
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-18-1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG. July 10, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 15 1969

JUL 31 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 29 1993

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

JUN 24 1969

Bureau of Vital Statistics

State File No. 2844
Local Reg. No. 176
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Hauser Lake
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway # 53

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	T.	White	June 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	C	Dec. 18, 1932	36		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fork Lift Operator	Lumber Mill	Hepner, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable	-------	Unobtainable	-----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean	541-34-8742	Helen M. Hippard (Mrs)	RT 1, Post Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Accidental Electrocution — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 95	Hauser Lake Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
m.		Car hit power pole Victim stepped on wire

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood M.D. Coroner	Coeur d'Alene Idaho	6-17-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-20-1969	Evergreen Cemetery	Post Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 18, 1969	Lorraine K. Brush	Bill Leuff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 25 1969

MAR 29 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2845
Local Reg. No. 173
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUN 27 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY IN THIS PLACE: 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print): a. (First) TILLIE; b. (Middle); c. (Last) AVERILL

4. DATE OF DEATH (Month) (Day) (Year): June 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Cau.	Widowed	Oct. 27, 1883	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	own home	Minnoesota	U.S..A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
No		Stanley Averill E.9623 Fairview Ct. Spokane, Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4123 Arteriosclerotic heard disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis and senile deterioration — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1955, 19__, *to* 6-16, 1969, *that I last saw the deceased alive on* 6-16, 69, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Coeur d'Alene Idaho	6-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	19/6/69	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 25, 1969	Lorraine K. Brush	Fred Noland	E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUN 24 1969 Bureau of Vital Statistics

State File No. 2846
Local Reg. No. 162
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 28	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeurd' Alene; c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 14 miles E. of CDA, Ida. 000	d. STREET ADDRESS (If rural, give location) 1128-Boyd Av

3. NAME OF DECEASED (Type or Print)	a. (First) Willard	b. (Middle) E.	c. (Last) Barr	4. DATE OF DEATH (Month) (Day) (Year) June 17, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH Jan. 15,1916	9. AGE (In years last birthday) 53; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hoist operator Engr. 01	10b. KIND OF BUSINESS OR INDUSTRY Minning	11. BIRTHPLACE (State or foreign country) Crane, Montana	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Barr	BIRTHPLACE Wisconsin	14. MOTHER'S MAIDEN NAME Mamie Garrow	BIRTHPLACE Wisconsin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 517-10-7592	17. INFORMANT'S OWN SIGNATURE Mary A. Barr	ADDRESS Idaho Coeur d'Alene	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood M.D. (Degree or title) Coroner 772	23b. ADDRESS Coeur d'Alene Idaho	23c. DATE SIGNED 6-17-'69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-20-1969	24c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery	24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho
DATE REC'D BY LOCAL REG. June 18, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Siplinger Jr.	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2847
Local Reg. No. 172
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUN 27 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this Place) 7 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE California b. COUNTY Los Angles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Redondo Beach
d. STREET ADDRESS (If rural, give location) 214 Catalina Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THOMAS	M.	ANDERSON	June 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Married	3/7/1886	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seaman 30	On Ships	Norway	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	551-24-3701A	A.C. Anderson	Coeur d' Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion, Massive, Fatal — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardio Vascular Disease — Chronic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia — 3-4 Days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 10, 1969, to June 18, 1969, that I last saw the deceased alive on June 17, 1969, and that death occurred at 8:00 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lynn C Erickson MD.	Coeur d' Alene, Idaho	6/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 20, 1969	Forest	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 25, 1969	Lorraine K. Brush	Frank Houde	E-521

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 1 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUN 27 1969 Bureau of Vital Statistics

State File No. 2848
Local Reg. No. 175
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
LENGTH OF STAY (In this place): 0-0-0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 818 "A" Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Hannah	J.	Martin	June 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	May 18, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Jackson	Not Available	Sophia Anderson	Not Available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-20-3830	William Martin (Ba)	Rathdrum, Ida

4124

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebro-vascular accident	48 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arterio-scleratic cardio-vascular disease, severe	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arthritis degenerative, severe	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Arthritis, left hip	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April, 1965, to June, 1969, that I last saw the deceased alive on June 19, 1969, and that death occurred at 11:40a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Don Moseley, M.D.	Coeur d'Alene, Idaho	6/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-23-1969	Forest Cemetery	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 26, 1969	Lorraine K. Brush	Bill Wolff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2849
Local Reg. No. 177
Reg. Dist. No. 120

RECEIVED
JUN 27 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
c. LENGTH OF STAY (In this city or place): 005
d. FULL NAME OF HOSPITAL OR INSTITUTION: Route #1, Box 172

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Route #1, Box 172

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Edna	Mae	Nolte	June 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	May 8, 1920	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Assembler	Clare-Pendar Co	Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Not Available	Not Available	Not Available	Not Available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (Sandra L Braden)	ADDRESS
NO	None	287-18-3304	Sandra L Braden (SW)	Coeur d'Alene, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 12:30a m *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
H. Don Moseley, M.D.	Coeur d'Alene, Idaho	6/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-24-1969	Forest Cemetery	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 25 1969	Lorraine K Brush	Bill Wolff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2850
Local Reg. No. 178
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 8 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Coeur d'Alene Homes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): Coeur d'Alene Homes

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ira	Lloyd	Boston	June 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	April 22, 1879	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Farmer	Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. H. Boston	----	Kate VanTuyler	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	535-18-8741	Mrs A C Marcus	3005-11th Spokane

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Senility and debility — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized asteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* never, 19____, to ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 12:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Wray Wilson MD	Coeur d'alene	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-25-1969	Pines Cemetery	Opportunity Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 27, 1969	Lorraine K. Brush	Bill Duff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Greenwood

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2851
Local Reg. No. 176
Reg. Dist. No. 120

BIRTH NO.

JUN 27 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 281 a. STATE Idaho b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene c. LENGTH OF STAY (If in this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 501 1st St Apt #87 000	d. STREET ADDRESS (If rural, give location) 501 1st St., Apt #87

3. NAME OF DECEASED (Type or Print) a. (First) Dorothy	b. (Middle)	c. (Last) McCollum	4. DATE OF DEATH (Month) June (Day) 22, (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Aug 31, 1900	9. AGE (In years last birthday) 68 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mark Chaffins	BIRTHPLACE West Virginia	14. MOTHER'S MAIDEN NAME Cornelia Morrison	BIRTHPLACE Minnesota	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 536-03-3268	17. INFORMANT'S OWN SIGNATURE Mary C. Roach (BD)	ADDRESS Coeur d'Alene, Ida	

18. CAUSE OF DEATH 4100
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	My cardial infarction Arterio sclerosis of Coronary Vessels	Few minutes 10 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertension	20 yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1938, *to* June 22, 1969, *that I last saw the deceased alive on* June 9, 1969, *and that death occurred at* 9:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 188 Hamilton H. Greenwood (Degree or title) MD	23b. ADDRESS Coeur d'Alene, Ida	23c. DATE SIGNED 6-23-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-26-1969	24c. NAME OF CEMETERY OR CREMATORY St Thomas Cemetery	24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho
DATE REC'D BY LOCAL REG. June 25, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 8 1969 Bureau of Vital Statistics

State File No. 2852
Local Reg. No. 182
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeurd' Alene c. LENGTH OF (If not in this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 110	d. STREET ADDRESS (If rural, give location) 522 Indiana

3. NAME OF DECEASED (Type or Print)	a. (First) Anna	b. (Middle) C.	c. (Last) Rarick	4. DATE OF DEATH (Month) June	(Day) 22,	(Year) 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH June 11, 1897	9. AGE (In years last birthday) 72	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Sask.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Healy	BIRTHPLACE ----------	14. MOTHER'S MAIDEN NAME Elizabeth McCann	BIRTHPLACE ---------			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 519-10-4555	17. INFORMANT'S OWN SIGNATURE Douglas R. Rarick	ADDRESS Coeur d'alene Ida			

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral hemorrhage

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gen. arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Residual of old stroke Parkinsons disease

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1969, *to* June 22, 1969, *that I last saw the deceased alive on* June 22, 1969, *and that death occurred at* 2:30 9 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD	23b. ADDRESS Coeur d'Alene Id	23c. DATE SIGNED 6/25/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-24-1969	24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d' Aleen, Ida.
DATE REC'D BY LOCAL REG. June 27, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Cluff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 8 1969
JUL 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

BIRTH NO. 69-6085

RECEIVED JUL 8 1969 Bureau of Vital Statistics

State File No. 2853
Local Reg. No. 179
Reg. Dist. No. 120

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 110

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 180
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hayden Lake
d. STREET ADDRESS (If rural, give location): Rt. 1 Box 158 C

3. NAME OF DECEASED (Type or Print)
a. (First): Kari
b. (Middle): Anne
c. (Last): Eddings

4. DATE OF DEATH (Month) (Day) (Year): June 24, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: June 23, 1969

9. AGE (In years last birthday): ----
IF UNDER 1 YR. Months: -- Days: 1
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 02

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Coeurd' Alene, Ida.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Eddings
BIRTHPLACE: Okla.

14. MOTHER'S MAIDEN NAME: Margaret Dial
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Joseph Eddings (RD) Coeurd'alene
ADDRESS: Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 7761 Hyalin Membrane disease — INTERVAL BETWEEN ONSET AND DEATH: at Birth

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Prematurity

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-23- , 1969 *to* 6-24 , 1969 *that I last saw the deceased alive on* 6-24 , 1969 *and that death occurred at* 9 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 251 W Hughes MD

23b. ADDRESS: Coeur D'Alene Idaho.

23c. DATE SIGNED: 6-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6-25-1969

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial

24d. LOCATION (City, town, or county) (State): Pk. Coeur d'Alene, Ida.

DATE REC'D BY LOCAL REG.: July 1, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Bill Huff

LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED JUL 8 1969 Bureau of Vital Statistics

State File No. 2854
Local Reg. No. 187
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
STAT (In this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bayveiw
d. STREET ADDRESS (If rural, give location): Box 71

3. NAME OF DECEASED (Type or Print): a. (First) Frank; b. (Middle) T.; c. (Last) Miller

4. DATE OF DEATH (Month) (Day) (Year): June 26, 1969

5. SEX: Male

6. COLOR OR RACE: Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 31, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Garage

10b. KIND OF BUSINESS OR INDUSTRY: own garage

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: A. B. Miller
BIRTHPLACE: UNKNOWN

14. MOTHER'S MAIDEN NAME: Josephine Hutton
BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 537-09-2584

17. INFORMANT'S OWN SIGNATURE: Hazel Miller
ADDRESS: Box 71 Bayveiw, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arterio Scleratic Cardio-vascular disease with decompensation — 10 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 6:45 p m., *from the causes and on the date stated above.*

24a. SIGNATURE: H. Don Moseley, M.D.
(Degree or title)

23b. ADDRESS: 421 Coeur d'Alene, Cd'A.

23c. DATE SIGNED: 6/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 6/27/69

24c. NAME OF CEMETERY OR CREMATORY: Thornhill-Geraghty

24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: June 30, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Harold Thornhill

LICENSE NO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thornhill-Geraghty Funeral Home

JUL 8 1969

JUL 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

State File No. 2855
Local Reg. No. 185
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 110

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 28
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 725 2nd St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Maria	Christina	Heyn	June	30	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced	1-26-1875	94		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Private	Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Pingel	Not Available	Not Available	Not Available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-66-6210	Edessa Heyn	Cda. Coeur d'alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction	Immed.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arterioscleratic, cardiovascular disease	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/27/69	Fracture right hip-comminuted	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 20, 1954, *to* June 30, 1969, *that I last saw the deceased alive on* June 30, 1969, *and that death occurred at* 11:25a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
H. Don Moseley, M.D.	421 Cd'A Ave. Coeur d'Alene	7/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-2-1969	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Laura M. K. Brush	Bill Huff	E-439

FIRM NAME: English Chapel-Coeur d' Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUN 30 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2856
Local Reg. No. 61
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 1 hr. 20'
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Nobby Inn

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bovill
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Peter	Hans	Nelson	May 29 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	never married	Oct 31, 1880	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
woodsman	Lumber	Allerstev, Denmark	Denmark

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-01-7057	X [signature] Second	Bovill Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) coronary atherosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] Coroner	Moscow Idaho	6/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 5, 1969	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
20 June 1969	Wayne R Heikkila	Donald W [illegible]	E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2857
Local Reg. No. 58
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JUN 17 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN: Moscow
c. LENGTH OF STAY IN THIS PLACE: 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 225 No. Home St.

3. NAME OF DECEASED (Type or Print): a. (First) Richard; b. (Middle) Allen; c. (Last) Burnvik

4. DATE OF DEATH: (Month) June (Day) 4 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: March 19, 1953

9. AGE (In years last birthday): 16 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Moscow, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Orville Burnvik — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Olga Schoening — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-64-0115

17. INFORMANT'S OWN SIGNATURE: X Orville D. Burnvik — ADDRESS: Moscow, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Rupture Left Pulmonary Artery — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Accident - Motorcycle
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Moscow, Latah, Ida.
21d. TIME OF INJURY: (Month) 6 (Day) 4 (Year) 69 (Hour) 6 pm.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: Motorcycle - car collision

22. *I hereby certify that I attended the deceased from* 6-4-69, *to* 6-4-69, *that I last saw the deceased alive on* 6-4-69 6 pm, *and that death occurred at* 11:07 pm, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David C. Valder M.D.
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 6-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 11 June 1969
REGISTRAR'S SIGNATURE: Wayne R Weinkauf
25. EMBALMER: Conrad Ward
LICENSE NO.: E-80

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUN 17 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2858
Local Reg. No. 59
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 7 Days 7
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 1.2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
d. STREET ADDRESS (If rural, give location) Box 84

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Howard	William	Sexton	June 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 8	Nov. 11, 1916	52				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 2	City of Moscow	Potlatch, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Sexton	Texas	Blanche Thompson	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Barbara Sexton	Troy, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 1940 — 1 month

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1957, *to* 6-4, 1969, *that I last saw the deceased alive on* 6-3, 1969, *and that death occurred at* 8:30 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
I/S Omer H Drury	M.D.	Troy Idaho	6-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 7, 1969	Palouse Cemetery	Palouse Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12 June 1969	Draper R Heiskari	E. Pete Albertson	E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 19 1969

FEB 19 1970

OCT 29 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUN 20 1969 Bureau of Vital Statistics

State File No. 2859
Local Reg. No. 173
Reg. Dist. No. 220

BIRTH NO.

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALICE	CAROLINE	GOSS	5 June 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	7 October 1907	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 67	Own Home	Hand County, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel Phillips	no record	Fanny E. Kintigh	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	539 14 3462	Fred Arnett	Kendrick, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4319 Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis — 5 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* June 4, 1969, *and that death occurred at* 1 AM m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D.A. Christensen M.D.	Kendrick, Idaho	6-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9 June 1969	Kendrick Cemetery	Kendrick, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-16-69	Alexander Walzer	W E Black	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES: JUN 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2860
Local Reg. No. 62
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED
JUN 30 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 32 Yrs. 132
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home 560

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print)
a. (First): Floy
b. (Middle): Adell
c. (Last): Youmans

4. DATE OF DEATH (Month) (Day) (Year): June 13, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 13, 1893
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Marble Hill, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Pinkney Caldwell — BIRTHPLACE: North Carolina
14. MOTHER'S MAIDEN NAME: Edith Peare — BIRTHPLACE: Kjudeas, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-26-8044B
17. INFORMANT'S OWN SIGNATURE: x Clyde Youmans — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic and
~~DUE TO (c)~~ Rheumatic Valvular disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* June, 1969, *that I last saw the deceased alive on* May, 1969, *and that death occurred at* 7:P.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wayne A Leff MD 1 751
23b. ADDRESS: 1804 No. Grand Pullman, Wash
23c. DATE SIGNED: 6-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Buried
24b. DATE: June 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 23 June 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided~~ in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED JUN 30 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2861
Local Reg. No. 60
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) Albert c. (Last) Herrmann

4. DATE OF DEATH (Month) (Day) (Year) June 15, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec. 9, 1891

9. AGE (In years last birthday) 77 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Stanburg, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Fred Herrmann
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-26-5908A

17. INFORMANT'S OWN SIGNATURE & ADDRESS Maynard F. Herrmann Moscow, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Pulmonary Fibrosis — 7 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 52, to June 14, 1969, *that I last saw the deceased alive on* 6-11, 1969, *and that death occurred at* 5:03 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Omer H Downy MD

23b. ADDRESS Troy Idaho

23c. DATE SIGNED 6-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 21, 1969

24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery

24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 20 June 1969

REGISTRAR'S SIGNATURE Maynard Herrmann

25. EMBALMER E. Pete Albertson

LICENSE NO. E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 27 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2862
Local Reg. No. 63
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JUN 30 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): most life 53
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 411 So. Lincoln

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 411 So. Lincoln

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Jean	Whitson	June	18	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Divorced	June 7, 1916	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary 14	University of Idaho	Oaksdale, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Humphrey	Linville, Idaho	Eula Grice	Moscow, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-5131	X Gail Sanders	Clarkston, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) coronary atherosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 583 Coroner	Moscow Idaho	6/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 21, 1969	Moscow Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
25 June 1969	Wayne L. Heiskori	E. Pete Albertson	E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 20 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2863
Local Reg. No. 64
Reg. Dist. No. 200

RECEIVED JUL 7 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Troy
c. LENGTH OF STAY (in this place) Hrs. 4/0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rural Ranch

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 53
b. COUNTY Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clarkston Rural
d. STREET ADDRESS (If rural, give location) 2206 6th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	NORMAN	ALBERT	BROOKS	June	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	2 Nov. 1954	14				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	School	Lewiston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. Curtice Brooks	Pomeroy, Wash.	Helen Niman	Chesterfield, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		NONE	J. Curtice Brooks	Clarkston, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9229

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial rupture — INTERVAL BETWEEN ONSET AND DEATH: unrec'd

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Gun shot wound -

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ■ NO ☐

21a. ACCIDENT XX / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
	Farm 02	Troy, Latah, Idaho 29

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
June 22, 1969 5p m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Bullet entered R. lateral chest & penetrated both ventricles

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 5p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] Coroner	Moscow Idaho	6/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	6-25-1969	Vineland Cemetery	Clarkston, Washington 99403

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
30 June 1969	Wayne R Heiskari	W C Merchant	FD5

FIRM NAME: Merchant Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2864
Local Reg. No. 65
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JUL 7 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington
b. COUNTY Whitman
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Uniontown
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print): a. (First) Mark b. (Middle) Peter c. (Last) Cole

4. DATE OF DEATH (Month) (Day) (Year): June 24, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 12, 1876

9. AGE (In years last birthday): 92
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Blue Earth, Minn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Cole
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Ambrosia South
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-44-5260

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Uniontown, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Spontaneous rupture of bladder — 2 days
DUE TO (c) Probable Carcinoma of bladder — months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-14, 1969, *to* 6-24, 1969, *that I last saw the deceased alive on* 6-24, 1969 *and that death occurred at* 5:45 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) M.D.

23b. ADDRESS: Moscow, Idaho

23c. DATE SIGNED: 6-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: June 28, 1969

24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 30 June 1969

REGISTRAR'S SIGNATURE: Wayne R Heiskari

25. EMBALMER: Donald Ward

LICENSE NO.: E-30

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2865
Local Reg. No. 66
Reg. Dist. No. 200

RECEIVED JUL 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 2 Hrs. 40

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 506 East Morton

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 1/2

3. NAME OF DECEASED (Type or Print): a. (First) Magdalene; b. (Middle); c. (Last) Heilman

4. DATE OF DEATH: (Month) June (Day) 27 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 12, 1905
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 4
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Odessa Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Garman — BIRTHPLACE: Russia
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: × William J. Heilman — ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4309

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sub Arechnoid Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aneurysm of Bas. Izr Artery — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-1, 1941, *to* 6-27, 1969, *that I last saw the deceased alive on* 6-27, 1969, *and that death occurred at* 11½ a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Earl Dunn MD
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 2 July 1969
REGISTRAR'S SIGNATURE: Wayne L Heikkari
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2866
Local Reg. No. 67
Reg. Dist. No. 200

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 2 Months 202
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 203 S. Howard

3. NAME OF DECEASED (Type or Print)
a. (First) Emanuel
b. (Middle) Joseph
c. (Last) Leopold

4. DATE OF DEATH (Month) (Day) (Year) June 30 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 26, 1900
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant 19
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New York City, New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Leopold — BIRTHPLACE Austria
14. MOTHER'S MAIDEN NAME Helen Lowenthal — BIRTHPLACE Lithuania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 064-07-1819A
17. INFORMANT'S OWN SIGNATURE X Joan Muneta — ADDRESS Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH 18 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1968, *to* June, 1969, *that I last saw the deceased alive on* June 28, 1969, *and that death occurred at* 1:35 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Claudette Weitz 691 (Degree or title) M.D.I.
23b. ADDRESS 1804 N Grand Pullman Wn
23c. DATE SIGNED July 3 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 2, 1969
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 10 July 1969
REGISTRAR'S SIGNATURE Mayne R Heeskari
25. EMBALMER Donald Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2867
Local Reg. No. 690
Reg. Dist. No.

RECEIVED JUN 19 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial (4 mos.)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) George b. (Middle) Washington c. (Last) Benjamin

4. DATE OF DEATH (Month) (Day) (Year): June 2, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 1, 1884

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): butcher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Benjamin
BIRTHPLACE: So.Bend, Ind.

14. MOTHER'S MAIDEN NAME: Mary Sutton
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-14-1539

17. INFORMANT'S OWN SIGNATURE: Virginia La Maire
ADDRESS: Salmon, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Prostate & metastases — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 1965, *to* June 2, 1969, *that I last saw the deceased alive on* June 2, 1969, *and that death occurred at* 5:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W Moore MD
23b. ADDRESS: Salmon Idaho
23c. DATE SIGNED: 6-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: 6-17-69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C Jones
LICENSE NO.: E 369
FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 1 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 9 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2868
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED STATE OF IDAHO

JUN 26 1969

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Killam Point 1.8 miles
c. LENGTH OF STAY (in this place): -0-
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): below end of Salmon River Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elba
d. STREET ADDRESS (If rural, give location): R.F.D.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Carla	* * *	Tuttle	June 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	never married	October 19, 1953	15				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student 23	school	Rupert, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theodore N. Tuttle	Oakley, Idaho	Lovina Chandler	Elba, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Louise A. C. Tuttle	Elba, Ida.

MEDICAL CERTIFICATION

8309

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by drowning — INTERVAL BETWEEN ONSET AND DEATH: -0-

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Salmon River 18	Killam Point	Lemhi 300	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
June 6, 1969 10:15A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Motor on boat quit, boat swamped in rapids

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Delbert C. Jones 583	Lemhi Co. Coroner	Salmon, Idaho	6-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	June 18, 1969	Elba Cemetery	Elba, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-24-69	Viola E. Johnson	Delbert C. Jones	E 369

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: JONES FUNERAL HOME

DUTIES: JUL 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2869
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED
JUN 19 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): life 185
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial Hosp. 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Don
b. (Middle): "J"
c. (Last): Pyeatt

4. DATE OF DEATH (Month) (Day) (Year): June 11, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 19, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lemhi, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas B. Pyeatt — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Pelisha Gill — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-32-4347A
17. INFORMANT'S OWN SIGNATURE: Dorothy P. Baker — ADDRESS: Idaho Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerosis generalized 6 mos
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with gangrene
DUE TO (c) rt leg — 10 days.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Benign Hypertrophy Prostate 6 mos.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1949, 19__, *to* Death, 19__, *that I last saw the deceased alive on* June 11, 1969 *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 045 W. H. Harhad M.D.
23b. ADDRESS: Salmon Idaho
23c. DATE SIGNED: 6-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: 6-17-69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: JONES FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2870
Local Reg. No. 690
Reg. Dist. No.

RECEIVED
JUN 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
LENGTH OF STAY (In this place): 40 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jane	Elizabeth	Ottestad	June 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FeMale	White	Widowed	Dec. 12, 1893	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
home		Osseo, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward James Henry	Wisc.	Ettie Leonis Johnson	Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-30-6426	Laura L. Benson	Salmon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial infarction	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Generalized arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Cerebrovascular disease	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5-9-[illegible], 1952, *to* 6-13, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 263 M.D.	Salmon, Idaho	6-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 16, 1969	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-19-69	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2871
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

RECEIVED
JUN 30 1969
Bureau of
STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY Lemhi 300
b. CITY OR TOWN Salmon
c. LENGTH OF STAY in this place few days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Steele Memorial Hosp. 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Challis
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Charles	Joseph	Ebberts	June 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 20, 1891	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired-State Hiway	& Forest Serv.	Challis, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph L. Ebberts 11	Pennsylvania	Emma DeMoss	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW #1	518-14-2242	Lula M. Ebberts	Challis

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesenteric Thrombosis-2d. & Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1960 19 *to* Death, 19 *that I last saw the deceased alive on* 6-17 19 69 *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Martha Davis M.D. 045	Salmon Ida	6-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-20-69	Challis	Challis, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-26-69	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2872
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

JUN 30 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: SanBernadino
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Yermo
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Marcus
b. (Middle): Bryan
c. (Last): Calhoun

4. DATE OF DEATH: June 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 13, 1896

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Austin, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Orlando Calhoun
BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Clara Virginia Boyd
BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW 1, USMC

16. SOCIAL SECURITY NO.: 519 01 0928A

17. INFORMANT'S OWN SIGNATURE: James B. Calhoun
ADDRESS: Canoga Pk, Cal.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4789

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 20, 1969, *to* June 21, 1969, *that I last saw the deceased alive on* June 20, 1969, *and that death occurred at* 1:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. Moore (Degree or title): M.D.
23b. ADDRESS: Salmon Idaho
23c. DATE SIGNED: 6-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: 6-26-69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert Jones
LICENSE NO.: E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 1 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2873
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 33 yrs 133
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Eva - (aka Evvy)
b. (Middle): Jane
c. (Last): Smith

4. DATE OF DEATH (Month) (Day) (Year): June 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 2
8. DATE OF BIRTH: Jan. 30, 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gainsville, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph P. Riteberger — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Mary Jane Whorton — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 280-20-9592
17. INFORMANT'S OWN SIGNATURE: Donald L Smith — ADDRESS: Detroit, Mich.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Massive -
DUE TO (c): Hypertension — 3 yr.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death*: Anaphaltic react to earlier 12 hr.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Ampicil orally
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__ *to* 69, 19__, *that I last saw the deceased alive on* June 28 1969 *and that death occurred at* 4:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. L. Blachadar MD
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: July 11 69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: JONES FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUN 6 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2874
Local Reg. No. 684
Reg. Dist. No. 430

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (In this place): 1 year 101
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ARTHUR (RAY)
b. (Middle): L.
c. (Last): GRANT

4. DATE OF DEATH (Month) (Day) (Year): June 1, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 27, 1885
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 11, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Fremont, Michigan
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John A. Grant — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Margaret Ellis — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 520-24-4998
17. INFORMANT'S OWN SIGNATURE: Nursing Home records — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 12 Days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1968 *to* June 1, 1969, *that I last saw the deceased alive on* May 27, 1969, *and that death occurred at* 11:35 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 386 1
23b. ADDRESS: Box 68 Shoshone Idaho
23c. DATE SIGNED: 6-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6-5-1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 6-4-69
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bergin Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2875
Local Reg. No. 085
Reg. Dist. No. 430

RECEIVED JUL 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
LENGTH OF STAY (in this place): 8½ yrs 109
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dietrich rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BESSIE	B.	BATE	June 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed 2	Aug. 31, 1887	81	9	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Parkston, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Floyd B. Gage	Fondluack, Wisconsin	Etta VanBanbechten,	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	519-44-7644	X Maude I Gage	Dietrich, Idaho

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Osteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1966, *to* June 30, 1969, *that I last saw the deceased alive on* June 26, 1969, *and that death occurred at* 12:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D. 386	Box 68 Shoshone Idaho	July 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-3-1969	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-2-69	Francis M. Bergin	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2876
Local Reg. No. 41
Reg. Dist. No. 630

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (If in place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rexburg Nursing Home 307

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony-Rural
d. STREET ADDRESS (If rural, give location): RFD#2

3. NAME OF DECEASED (Type or Print)
a. (First): ALICE
b. (Middle): ELNORA ANDERSON
c. (Last): ERICKSON McFARLAND

4. DATE OF DEATH (Month) (Day) (Year): May 29, 1969

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 31, 1891
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months 11, Days 28 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife and farm Owner 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Wellsville, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John A. Anderson — BIRTHPLACE: Ekskaraborg, Sweden
14. MOTHER'S MAIDEN NAME: Emma Ohlson — BIRTHPLACE: Hemjo. Alsborg, Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-40-3710
17. INFORMANT'S OWN SIGNATURE: Edna Moore — ADDRESS: RFD#2 St. Anthony, I daho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis — 10 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 26, 1967, *to* May 29, 1969, *that I last saw the deceased alive on* April 30, 1969, *and that death occurred at* 7:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. Louval, M.D. 537
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 5-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 31 May 69
24c. NAME OF CEMETERY OR CREMATORY: Parker Cemetery
24d. LOCATION (City, town, or county) (State): Parker, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 6-24-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: M. D. Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 19 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2877
Local Reg. No. 37
Reg. Dist. No. 630

RECEIVED JUL 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 33
b. CITY OR TOWN (If outside corporate limits, write RURAL and give place): Rexburg
c. LENGTH OF STAY IN THIS PLACE: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 23

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 33
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NELLE	CHILD	PORTER	June 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	January 2, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 61
10b. KIND OF BUSINESS OR INDUSTRY: 52
11. BIRTHPLACE (State or foreign country): Ogden, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Austin Wilder Child — BIRTHPLACE: Ogden, Utah
14. MOTHER'S MAIDEN NAME: Mary Louise Thompson — BIRTHPLACE: Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: x John [illegible] — ADDRESS: Rexburg, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Abdominal aneurysm, rupture — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — several years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1966, *to* 6-11, 1969, *that I last saw the deceased alive on* 6-11, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] Peterson MD
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 6-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/13/69
24c. NAME OF CEMETERY OR CREMATORY: Rexburg
24d. LOCATION (City, town, or county) (State): Rexburg Idaho

DATE REC'D BY LOCAL REG.: 6-13-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: [signature] Flamm
LICENSE NO.: E347
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (RCA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2878
Local Reg. No. 38
Reg. Dist. No. 630

BIRTH NO.

RECEIVED JUL 16 1969 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Rexburg
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 126 East 1st North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 126 East 1st North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EVAN	R.	LEWIS	June 18 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	January 1, 1953	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03		Rexburg, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Rulon Lewis	Rexburg, Idaho	Leila Richards	Moore, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Michael R. Lewis	San Diego Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2040

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Lymphoblastic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 1 Month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Tonsillitis & Bronchitis — 4 months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 1, 1953, *to* June 18, 1969, *that I last saw the deceased alive on* June 18, 1969, *and that death occurred at* 10 30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. F. Bigler M.D.	Rexburg Idaho	June 20 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/21/69	Rexburg	Rexburg Madison Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-20-69	Leona Flamm	Kenneth R. Flamm	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2879
Local Reg. No. 39
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 60
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): Rt.1

3. NAME OF DECEASED (Type or Print)
a. (First): Emil
b. (Middle): Robert
c. (Last): Hedelius

4. DATE OF DEATH (Month) (Day) (Year): June 25, 1969

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 7, 1894
9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Carl Hedelius
BIRTHPLACE: Norcoping, Sweden
14. MOTHER'S MAIDEN NAME: Charlotte Maria Anderson
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-40-8258
17. INFORMANT'S OWN SIGNATURE: Vilate Hedelius
ADDRESS: Rexburg RT.1

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 da

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Cerebral arteriosclerosis — several years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetes mellitus — 15 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1960, *to* June 25, 1969, *that I last saw the deceased alive on* June 25, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lester J. Peterson MD
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: 6-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/28/69
24c. NAME OF CEMETERY OR CREMATORY: Burton Cemetery
24d. LOCATION (City, town, or county) (State): Burton Madison, Idaho

DATE REC'D BY LOCAL REG.: 6-28-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Russell Flamm
LICENSE NO.: E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAR 19 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2880
Local Reg. No. 40
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 0.00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Leland
c. (Last): Mortensen

4. DATE OF DEATH (Month) (Day) (Year): June 27, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: September 13, 1892
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hyrum, Utah
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Peter Mortensen — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Hannah Maria Jensen — BIRTHPLACE: Hyrum, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: James Max Mortensen — ADDRESS: Rexburg, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Myocardial Disease — 2 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes Mellitus — 6 yrs.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — 1965, *to* 6-27, 1969, *that I last saw the deceased alive on* 6-27, 1969, *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: O D H Jensen 233 (Degree or title): MD
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/2/69
24c. NAME OF CEMETERY OR CREMATORY: Sugar City
24d. LOCATION (City, town, or county) (State): Sugar City Madison Idaho

DATE REC'D BY LOCAL REG.: 7-2-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Kenneth B. Flamm — LICENSE NO.: E347

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended 12/14/77

Certificate of Death

STATE OF IDAHO

State File No. 2881
Local Reg. No. 22
Reg. Dist. No. 6 30

BIRTH NO.

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 33
b. CITY OR TOWN: Rexburg-Rural
c. LENGTH OF STAY (in this place): 00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho Hiway 88

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Calif. 05
b. COUNTY: Los Angeles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Saugus
d. STREET ADDRESS (If rural, give location): 19654 Newhouse Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOAN	INA	GILMAN Monhollen	June 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Married	Feb., 18, 1935	34				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		New York City, N. Y.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leonard Gilman	New York City, N. Y.	Pauline Schwartz	New York City, N. Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		M. D. Hansen	For William Monhollen

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crush chest internal injuries

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) automobile accident

DUE TO (c) DOA on arrival at

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Madison Memorial Hosp 7:25 PM

INTERVAL BETWEEN ONSET AND DEATH: 0

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ray Mabey 317 M.D.	Rexburg Idaho	7/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	1 July 69		Los Angeles, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7/1/69	Lona Flamm	M. D. Hansen	E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Cha el

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

12/14/77

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED
VITAL STATISTICS
DEC 14 1 11 PM '77

Affidavit to Correct or Amend an Original Certificate of Birth or Death

State of ..... } ss.
County of ..... }

Certificate No. 69-2881

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death) for Joan Ina Gilman Monhallen (Name on Original Certificate) who died (Was Born or Died) on June 30, 1969 (Date of Event) in Rexburg (rural), Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date) are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name	Monhallen	Monhollen
Informant's name	Robert Monhollen	William Monhollen

Subscribed and sworn to before me this 14th day of December, 19 77

Margaret D. Dare

Notary Public, residing at Ryan

My commission expires Lifetime

(Seal)

Signed Myrna Monhollen

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

X 19654 Nordhouse Canyon Country Calif

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.
County of ..... }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this ..... day of ....., 19.....

Notary Public, residing at .....

My commission expires .....

(Seal)

Signed .....

(Signature of Any Credible Person)

.....

(Street Address, City, State)

FORM DH 60-155

Child's birth certificate issued by State of California 7/26/61 lists parents as Joan Ina Gilman, Mother and William Love Monhollen, Father. viewed by Vital Statistics.

DEC 14 1977

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2882
Local Reg. No. 43
Reg. Dist. No. 450

Certificate of Death

RECEIVED JUN 23 1969

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN: Rupert
c. LENGTH OF STAY (in this place): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.G. Minidoka Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN: Rupert
d. STREET ADDRESS (If rural, give location): 914 2nd Street

3. NAME OF DECEASED (Type or Print)
a. (First): Max
b. (Middle):
c. (Last): Casias Sr.

4. DATE OF DEATH: (Month) (Day) (Year): June 13, 1969

5. SEX: male

6. COLOR OR RACE: Spanish

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 1, 1906

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railroad Maintainence Man

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ignacio, Colorado

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Phillip Casias
BIRTHPLACE: Spain

14. MOTHER'S MAIDEN NAME: Julia Samosa
BIRTHPLACE: New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 524-18-7287

17. INFORMANT'S OWN SIGNATURE: Max Casias
ADDRESS: Rupert, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): General Arteriosclerosis
DUE TO (c): Diabetes Mellitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Left Hemi Paresis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1/15/67, 19___, *to* 5/19/69, 19___, *that I last saw the deceased alive on* 5/19/69, 19___, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE: T. J. Telford 545 (Degree or title): MD
23b. ADDRESS: 153 Blue Lakes Blv'd North, T.F.
23c. DATE SIGNED: 6/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/17/69
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: 6-20-69
REGISTRAR'S SIGNATURE: Mary Ellen Jackson
EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 2 3 1969

JAN 7 1983

MAY 2 0 1996

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

*STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2883
Local Reg. No. 42
Reg. Dist. No. 452

BIRTH NO.

RECEIVED JUN 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 214 South Second Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Josiah	Richardson	BRAEGGER	June 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	January 9, 1912	57		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Building Contractor	Construction	Malad, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oliver Braegger	Willard, Utah	Ruth Richardson	Malad, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - -	518-12-5641	Pulsa Braegger	Rupert, Idaho

4709

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) No known prior to this attack
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 10, 1968, *to* June 14, 1969, *that I last saw the deceased alive on* June 14, 1969, *and that death occurred at* 10:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jan K. Humphreys	MD	Rupert Idaho	6-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 17, 1969	Rupert, Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-20-69	Mary Ellen Carlson	Charles J. Persons	E-494

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Walk Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 14 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2884
Local Reg. No. 44
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) one
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 806 Second Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Reinhold	J.	L. SCHULZ	June 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	August 29, 1875	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (Retired)	Agriculture	Chicago, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Schulz	Germany	Bertha Troyke	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - -	518-60-3158	Gilbert F. Hunter	Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) General debility of age.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 20, 1969, *to* June 28, 1969, *that I last saw the deceased alive on* June 25, 1969, *and that death occurred at* 7:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. W. Crawford MD	Rupert Idaho	2 July 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 1, 1969	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-9-69	Mary Grant Carlson	Charles L. Parsons	E-294

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Walk Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2885
Local Reg. No. 188
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 351 JUL 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 2 [illegible]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): P.F.I. MILL POND

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CLEARWATER 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): OROFINO
d. STREET ADDRESS (If rural, give location): CAVENDISH RD.

3. NAME OF DECEASED (Type or Print)
a. (First): CLAIR
b. (Middle): C.
c. (Last): CHAMBERLAIN

4. DATE OF DEATH (Month) (Day) (Year): (Found) 10 July 1969

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: 23SEPT. 1893
9. AGE (In years last birthday): 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAIL CARRIER 08
10b. KIND OF BUSINESS OR INDUSTRY: U.S. POSTAL DEPT.
11. BIRTHPLACE (State or foreign country): MINNESOTA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE CHAMBERLAIN — BIRTHPLACE: no/record
14. MOTHER'S MAIDEN NAME: GEORGIA ? ? — BIRTHPLACE: no/record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no/record
17. INFORMANT'S OWN SIGNATURE: Jack E. Chamberlain, W.E.B. — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8300

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: monents

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): drowning
DUE TO (c): possible internal injuries

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Clearwater River, 6 miles West of Orofino, Idaho 18
21c. (CITY, TOWN, OR TOWNSHIP): rural — (COUNTY): Clearwater 180 — (STATE): Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): LAST SEEN 24 Feb 1969 m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Boat capsized while deceased was fishing.

22. *I hereby certify that I attended the deceased from* - - - - - -, 19 - -, *to* - - - - - -, 19 - -, *that I last saw the deceased alive on* - - - - -, 19 - -, *and that death occurred at* 8 a.m. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Ducla 583 — (Degree or title): CORONER 4
23b. ADDRESS: 419 Stewart, Lewiston, Idaho
23c. DATE SIGNED: 10 Jul 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Cremation
24b. DATE: Removal 10 Jul 1969
24c. NAME OF CEMETERY OR CREMATORY: Ball & Dodd Crematory
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 7-11-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W. E. Black — W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 27 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 20 2008

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

DR. L. CRISMON

State File No. 2886
Local Reg. No. 164
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 JUN 9 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF (If outside place): Dys 300
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 3828 Barr Rd.

3. NAME OF DECEASED (Type or Print)
a. (First): Thomas
b. (Middle): J.
c. (Last): McGree

4. DATE OF DEATH (Month) (Day) (Year): June 1 69

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 24 1889
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Butte, Montana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nicholas J. McGree — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Elizabeth Hickey — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 518-16-8761
17. INFORMANT'S OWN SIGNATURE: Aletha O. McGree — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Possible Pericarteritis Nodosa. — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Emphysema

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Lewiston Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 27, 1969, *to* 6 1, 1969, *that I last saw the deceased alive on* 6 1, 1969 *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. Crismon 114 MD
23b. ADDRESS: St Johns Way
23c. DATE SIGNED: 6 2 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: June 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 6-5-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: Robert D. Larrabee — LICENSE NO.: QL 802
FIRM NAME: Merchant Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAR 1 1 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2887
Local Reg. No. 167
Reg. Dist. No. 220

RECEIVED
JUN 20 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 551
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): Minutes 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 1238 12th Street

3. NAME OF DECEASED (Type or Print)
a. (First): HARRY
b. (Middle): C
c. (Last): BROBST

4. DATE OF DEATH (Month) (Day) (Year): June 2, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 5
8. DATE OF BIRTH: Nov 26, 1889
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY: Auto
11. BIRTHPLACE (State or foreign country): Walla Walla, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Brobst — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Bessie Ferguson — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: 519 09 3047A
17. INFORMANT'S OWN SIGNATURE: Eva Brobst — ADDRESS: Clarkston, Wash

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	acute. Ventricular fibrillation	5 min.
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. — DUE TO (b)	Chronic congestive Heart failure.	1± month.
DUE TO (c)	Coronary artery heart disease.	15+ years
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Hypertension.	1+ year.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1954, *to* 2 June, 1969, *that I last saw the deceased alive on* 12 May, 1969, *and that death occurred at* 8 30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B R Stein M.D. 1
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 6 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: June 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland
24d. LOCATION (City, town, or county) (State): Clarkston, Washington 99403

DATE REC'D BY LOCAL REG.: 6-9-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: M C Merchant
LICENSE NO.: FD 5

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2888
Local Reg. No. 184
Reg. Dist. No. 220

Certificate of Death

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): DOA 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 1521 Grelle Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): OCEA
b. (Middle): EDWARD
c. (Last): BROWN

4. DATE OF DEATH (Month) (Day) (Year): 2 June 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 7 Dec. 1895
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman 06
10b. KIND OF BUSINESS OR INDUSTRY: Hi-Way Dept.
11. BIRTHPLACE (State or foreign country): Stroude, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas J. Brown — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Katherine McDowell — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 38 1784
17. INFORMANT'S OWN SIGNATURE: Robert R. Viers — ADDRESS: Lewiston, Idah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7963

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause of death not determined

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Presumed to be from
DUE TO (c) natural causes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 9 a.m. *m., from the causes and on the date stated above.*

23a. SIGNATURE: R. C. Colburn 098 (Degree or title) MD
23b. ADDRESS: 307 St Johns Way, Lewiston Ida
23c. DATE SIGNED: 7-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7 June 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 7-8-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W. E. Black — W E Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2889
Local Reg. No. 171
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUN 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 2 days 302
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino 180
d. STREET ADDRESS (If rural, give location): 721 Riverside

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): Louis
c. (Last): LaVOIE

4. DATE OF DEATH (Month) (Day) (Year): June 2, 1969

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Sept. 22, 1909
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): plumber 21
10b. KIND OF BUSINESS OR INDUSTRY: self-employed
11. BIRTHPLACE (State or foreign country): Craigmont, Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Alfonse LaVoie — BIRTHPLACE: Quebec, Canada
14. MOTHER'S MAIDEN NAME: Amelia DesChamps — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 519 09 3548
17. INFORMANT'S OWN SIGNATURE: Mary LaVoie — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

450X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Probable Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Asthma

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 1, 1969, *to* 6 2, 1969, *that I last saw the deceased alive on* 6 1, 1969, *and that death occurred at* 5 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: St Johns Way
23c. DATE SIGNED: 6 3 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 6-13-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 2 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 25 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 20 1969 Bureau of Vital Statistics

State File No. 2890
Local Reg. No. 166
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 350
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) U. S. Highway #12, Cherry Lane 020
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 20 miles East of Lewiston 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Peck
d. STREET ADDRESS (If rural, give location) no record

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) V. c. (Last) Nelson

4. DATE OF DEATH (Month) (Day) (Year) June 7, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH June 14, 1950

9. AGE (In years last birthday) 18 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 06

10b. KIND OF BUSINESS OR INDUSTRY construction

11. BIRTHPLACE (State or foreign country) Mountain Home, Arkansas

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME James A. Nelson BIRTHPLACE Oakland, Arkansas

14. MOTHER'S MAIDEN NAME Lula Todd BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 430-96-5803

17. INFORMANT'S OWN SIGNATURE Opal A. Todd ADDRESS Peck, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock - Loss - Drowning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Auto Accident

DUE TO (c) Auto into River

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Unk.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Acc.

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hwy 95

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) May 25 1969 ? p.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐ Unk

21f. HOW DID INJURY OCCUR? Auto into River

22. I hereby certify that I attended the deceased from X, 19__, to X, 19__, that I last saw the deceased alive on X, 19__, and that death occurred at X m., from the causes and on the date stated above.

23a. SIGNATURE Milfred J. Duclos (Degree or title) CORONER

23b. ADDRESS Lewiston, Idaho

23c. DATE SIGNED 6-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) removal

24b. DATE June 9, 1969

24c. NAME OF CEMETERY OR CREMATORY Mt. Home, Arkansas

24d. LOCATION (City, town, or county) (State) Mt. Home, Baxter County, Arkansas

DATE REC'D BY LOCAL REG. 6-12-69

REGISTRAR'S SIGNATURE [illegible]

25. EMBALMER V. Vassar LICENSE NO. E297

FIRM NAME Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Body into river May 25th Recovered from river JUNE 7, 1969

Certificate of Death

STATE OF IDAHO

State File No. 2891
Local Reg. No. 174
Reg. Dist. No. 220

RECEIVED
JUN 20 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 2 weeks 3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lapwai
d. STREET ADDRESS (If rural, give location): rural

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 135

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Iva Grace Belt

4. DATE OF DEATH (Month) (Day) (Year): June 9, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Feb. 2, 1904

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Pennyslvania

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Bishop
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Minnie Baker
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: X Courtney W Belt
ADDRESS: Lapwai, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occ — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — 3 mo.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 69, *to* June 9, 19 69, *that I last saw the deceased alive on* June 9, 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John Ee Carlson MD

23b. ADDRESS: 9th and Main Street Lewiston, Idaho

23c. DATE SIGNED: 6/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: June 13, 1969

24c. NAME OF CEMETERY OR CREMATORY: Normal Hill cemetery

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 6-18-69

REGISTRAR'S SIGNATURE: Glenadine Dalzell

25. EMBALMER: V. Vassar
LICENSE NO.: E297

FIRM NAME: Vassar-R wls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUN 20 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2892
Local Reg. No. 169
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce (35)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): ccc
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington (53)
b. COUNTY: Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 836 12th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	L.	SASAMAN	June	9	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed (7)	20 - July 1881	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (71)
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Catawissa, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jeremy Sasaman — BIRTHPLACE: (U N K N O W N)
14. MOTHER'S MAIDEN NAME: Minnie Richards — BIRTHPLACE: (U N K N O W N)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1903
16. SOCIAL SECURITY NO.: 518-01-1452
17. INFORMANT'S OWN SIGNATURE: Lois Easterday — ADDRESS: Clarkston, Wn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/11/49, 19___, *to* 6/9/, 19 69, *that I last saw the deceased alive on* June 9, 19 69, *and that death occurred at* 9:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: John E. Carsson (OSS) (Degree or title): MD
23b. ADDRESS: J.E. Carsson Bldg. Lewiston, Ida.
23c. DATE SIGNED: 6/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 11-June-1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 6-13-69
REGISTRAR'S SIGNATURE: Glenna Walgren
25. EMBALMER: W.C. Merchant
LICENSE NO.: FD 5

FIRM NAME: Merchant Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2893
Local Reg. No. 176
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NezPerce 351 JUN 20 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston, Mannor 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 351
d. STREET ADDRESS (If rural, give location) 314-5th Ave

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle)
c. (Last) Bashor

4. DATE OF DEATH (Month) 6 (Day) 10 (Year) 69

5. SEX male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Sept, 28-1889
9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 79
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Longmont, Calo,
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John D. Bashor BIRTHPLACE Tenn.
14. MOTHER'S MAIDEN NAME Ida Mae Brooke BIRTHPLACE Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 569-20-1052
17. INFORMANT'S OWN SIGNATURE Keith C. Bashor ADDRESS Englewood, Colo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION 203X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) multiple Myeloma

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-10, 1969, *to* _____, 19__, *that I last saw the deceased alive on* 6 9, 1969, *and that death occurred at* ±3 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 114
23b. ADDRESS St John's Way 6 6 0 1 6 9
23c. DATE SIGNED 6 18 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 14, 1969
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG. 6-18-69
REGISTRAR'S SIGNATURE Glenara Dalzen
25. EMBALMER Andrew F. Vassar
LICENSE NO. E315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 11 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 13 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 2 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2894
Local Reg. No. 183
Reg. Dist. No. 220

RECEIVED JUL 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nezperce, 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (In this place): 11 days 311
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nezperce
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Mc Kinley	J.	Bostic	June	10,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	married 3	Aug 21 1897	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber 27		Pipestone County, Minnesota	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Bostic		Margaret Kizer	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW I 1918-19	519 30 8679 A	Lena Mae Bostic	Nezperce

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pericarditis 4123	8 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Papillary muscle dysfunction.	3+ months
DUE TO (c)	Coronary artery sclerosis.	3++ months
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 30 May, 1969, *to* 10 June, 1969, *that I last saw the deceased alive on* 10 June, 1969, *and that death occurred at* 1 30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B R Stein 4/96	MD	Lewiston, Idaho	30 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 14 69	Community	Nezperce, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-7-69	Elmara Walzen	Elbert Uhlorn	E 421

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 1 7 1969

Certificate of Death

STATE OF IDAHO

State File No. 2895
Local Reg. No. 1775
Reg. Dist. No. 330

RECEIVED JUL 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
c. LENGTH OF STAY (in this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 357
d. STREET ADDRESS (If rural, give location): 816 13th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MILLIE		CROZIER	June 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	Dec. 9, 1872	96				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	at home	Ontario, Canada	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Johnston	Irerland	Ann Mawhinney	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518 36 4871A	X Mrs. Nancy Crozier	Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congestive Heart Failure — 1 mo.

DUE TO (c) Arteriosclerotic Heart Disease — years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-10, 1967, *to* 6-11, 1969, *that I last saw the deceased alive on* 6-9, 1969 *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. H. Hinson MD	Lewiston, Idaho	6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	June 13, 1969	Normal Hill cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-30-69	Glenna Walzer	V. Vassar	E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2896
Local Reg. No. 172
Reg. Dist. No. 220

Certificate of Death

RECEIVED
JUN 20 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): monents 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Innersection, 17thSt&19thAve. 0-0

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 3429 - 11th Street

3. NAME OF DECEASED (Type or Print)
a. (First): MARION
b. (Middle): ELMER
c. (Last): EDMONSON

4. DATE OF DEATH (Month) (Day) (Year): JUNE 11, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 3 Nov 1903
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumbering
11. BIRTHPLACE (State or foreign country): Orofino, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Edmonson — BIRTHPLACE: Michigan
14. MOTHER'S MAIDEN NAME: Texie Carr — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 518 03 8768A
17. INFORMANT'S OWN SIGNATURE: Marion E. Edmonson — ADDRESS: Lewiston, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): shock and Hemhorrage — INTERVAL BETWEEN ONSET AND DEATH: monents

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): head injuries & body injuries
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: hit by auto

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 17 ave, 17 st 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Lewiston nez Perce 351 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 11, '69 9:17 PM
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Struck by auto while crossing street.

22. *I hereby certify that I attended the deceased from* XX, 19__ *to* XX, 19__, *that I last saw the deceased alive on* XXXXX, 19__, *and that death occurred at* 9:17 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J Duclos 583 (Degree or title): Coroner 4
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 6/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 14 June 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 6-13-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2897
Local Reg. No. 168
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUN 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1St.Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Montana
b. (Middle): C. Lueck
c. (Last): Hunter

4. DATE OF DEATH (Month) (Day) (Year): June 11 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 5-26-25
9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bar maid 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sheridan, Montana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Lueck — BIRTHPLACE: Sheridan, Montana
14. MOTHER'S MAIDEN NAME: Miriam Pray — BIRTHPLACE: Potasdam, N.Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 516-30-25552
17. INFORMANT'S OWN SIGNATURE: X Sherry Da Clary — ADDRESS: Enaville Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

965X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shock Hemorrage
ANTECEDENT CAUSES: Gunshot Wounds
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Homicide 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 1613-G St 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Lewiston, NezPerce, Idaho. 351
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 11, 1969 10:20A.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: She was shot in Left Temple

22. *I hereby certify that I attended the deceased from* XX *19*__ *to* XX *19*__, *that I last saw the deceased alive on* XX *19*__, *and that death occurred at* 10:20A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duclos 583 (Degree or title): Coroner 4
23b. ADDRESS: Lewiston, Idaho.
23c. DATE SIGNED: 6-11-1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 5
24b. DATE: 6-13-1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Memorial Garden
24d. LOCATION (City, town, or county) (State): Pinehurst, Idaho.

DATE REC'D BY LOCAL REG.: 6-13-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: Andrew F. Vassar
LICENSE NO.: E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 3 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2898
Local Reg. No. 170
Reg. Dist. No. 220

RECEIVED JUN 20 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN: Lewiston
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1613-G. St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN: Stites
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Wesley	H.	HUNTER	June 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	cauc.	Married	3/16/26	43				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Harpster, Idaho.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Garrett Hunter	Whiteborro, Tex.	Lillie Holland,	Whiteborro, Tex.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	W.W.I	518-22-5293	X Edna M Trossett	Kamiaha, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock and Hemhorrage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) gunshot wounds
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
2 Suicide	1613 G At 04	Lewiston, NezPerce 351 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
June 11, 69 1013Am	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Self inflicted gunshot in head

22. *I hereby certify that I attended the deceased from* XX, 19___, *to* XX, 19___, *that I last saw the deceased alive on* XX, 19___, *and that death occurred at* 10:13AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Melfred L Duclos 535 coroner 4	Lewiston, Idaho	6/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	June 11, 1969	Harpster Cemetery	Harpster, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-13-69	Leonard Walgen	Andrew F. Vassar	E315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 23 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2899
Local Reg. No. 177
Reg. Dist. No. 220

RECEIVED
JUN 30 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Vincent none Clearwater River

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington b. COUNTY Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dayton
d. STREET ADDRESS (If rural, give location) R.F.D. #3

3. NAME OF DECEASED (Type or Print) a. (First) Vincent b. (Middle) c. (Last) SOWDER

4. DATE OF DEATH (Month) (Day) (Year) 6/11/69 see reverse

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 4/1/1920
9. AGE (In years last birthday) 49
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Mech.
10b. KIND OF BUSINESS OR INDUSTRY Self employed
11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Ward Sowder
BIRTHPLACE Unk.
14. MOTHER'S MAIDEN NAME Maria Hendrickson
BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1943-1945
16. SOCIAL SECURITY NO. 468-16-2733
17. INFORMANT'S OWN SIGNATURE J K Sowder ADDRESS Box C. Dayton Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock Poss. Drowning
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Auto Accidnt into river

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Acc
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hwy 95
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) May 25th 69 ? m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Auto ran into river

22. I hereby certify that I attended the deceased from _____, 19__ to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 10:10am m., from the causes and on the date stated above.

23a. SIGNATURE Wilfred L. Douglas (Degree or title) coroner
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 6/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 6/11/1969
24c. NAME OF CEMETERY OR CREMATORY Dayton City Cemetery
24d. LOCATION (City, town, or county) Dayton (State) Washington

DATE REC'D BY LOCAL REG. 6-23-69
REGISTRAR'S SIGNATURE Glenard Dalgren
25. EMBALMER Andrew H. Vassar
LICENSE NO. E 315
FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 15 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 12 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Time of death stated Item 4 June 11, 1969 was when body was taken from the river. Date body went into river same as Item 21b, May 25, 1969.

Wilfred J. Duclos, Coroner

State File No. 2900
Local Reg. No. 85
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

Amended

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Orofino
c. LENGTH OF STAY (in this place): Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 Mi. E.-Milepost 49 US. Hiway 12 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Grangeville 83530
d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print)
a. (First): Carol
b. (Middle): Christine
c. (Last): Stuivenga

4. DATE OF DEATH (Month) (Day) (Year): 5 11 1969

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single 1
8. DATE OF BIRTH: 2-14-1950
9. AGE (In years last birthday): 19 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookeeper 19
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Hospital
11. BIRTHPLACE (State or foreign country): Grangeville, Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: William C. Stuivenga — BIRTHPLACE: Idaho Grangeville
14. MOTHER'S MAIDEN NAME: Geneva Bos — BIRTHPLACE: Boseman, Mont.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-66-4029
17. INFORMANT'S OWN SIGNATURE: William C. Stuivenga — ADDRESS: Grangeville

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Asphyxiation due to drowning — INTERVAL BETWEEN ONSET AND DEATH: Sec.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Automobile accident
DUE TO (c): car in river

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Rural Orofino 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Orofino Clearwater Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 5-11-69 5:30P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Car drove into Clearwater River.

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 5:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title): Coroner 4
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: June 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Dec. 8, 1969
REGISTRAR'S SIGNATURE: Zern M. Burger
25. EMBALMER: Robert P. Hansen — LICENSE NO.: E433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

CORONERS REPORT

December 9, 1969

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

CAROL CHRISTINE STUIVENGA
Route 2
Grangeville, Idaho 83530

DOB 2-14-50
DOD 5-11-69
SS# 518-66-4029

Please refer to report of J. R. Admyer, State Trooper, Idaho State Police, Complaint form, Sheriff's Office, County of NezPerce, Lewiston, Idaho and letter from William J. Dee, Attorney at Law, Grangeville, Idaho.

Miss Stuivenga died on the 11th day of May, 1969, the result of a one car accident 5 Miles East of Orofino, Idaho on U. S. Hiway 12. Death was due to drowning when the car went into the Clearwater River and she was unable to swim to shore.

The body was not recovered until the 13th day of June, 1969. It was discovered by a Mr. William Weir floating in the Clearwater River just above the Washington Water Power Dam at Lewiston, Idaho. Recovery was made by M. W. Goins, Deputy, NezPerce County Sheriff's Office and Dave Johnson, Idaho State Police.

Due to lack in communications, Wilfred Duclos, Coroner for NezPerce County signed a death certificate which is void since death in fact was in Clearwater County, Idaho. A new Certificate of Death has this date been issued and recorded with the Registrar's office, Public Health Unit, Orofino, Idaho.

No further investigation is deemed necessary.

W. F. Shields, Coroner
Clearwater County, Idaho

Certificate of Death

STATE OF IDAHO

State File No. 2900
Local Reg. No. 173
Reg. Dist. No. 220

RECEIVED
JUN 20 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 005
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater above Dam 001

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Rural Rt # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Carol	Christine	STUIVENGA	June	13,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Single	February 14, 1950	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper 19
10b. KIND OF BUSINESS OR INDUSTRY: General Hospital
11. BIRTHPLACE (State or foreign country): Grangeville, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Stuivenga — BIRTHPLACE: Grangeville, Ida
14. MOTHER'S MAIDEN NAME: Geneva Bos — BIRTHPLACE: Bozeman, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518 66 4029
17. INFORMANT'S OWN SIGNATURE: William Stuivenga — ADDRESS: Grangeville, Ida

8169

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Asphixiation
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): drowning
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Auto Accident

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Clearwater River 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ XX
21f. HOW DID INJURY OCCUR? Accident auto into river

22. *I hereby certify that I attended the deceased from* XX, 19—, *to* XX, 19—, *that I last saw the deceased alive on* XX, 19—, *and that death occurred at* 6:40 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wallace J. Ducos 583 Coroner
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 6/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: Robert R Hansen — LICENSE NO.: E 433
FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Body taken from the Clearwater River App 1000 feet West of WWP Dam Lewiston, 6/13/69 App 6:40 PM by Coroner

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2901
Local Reg. No. 178
Reg. Dist. No. 220

BIRTH NO.

JUL 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manon Nursing Home 372

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 620 - 19th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): GLADYS
b. (Middle): CLAIRE
c. (Last): SCHIMPF

4. DATE OF DEATH (Month) (Day) (Year): 18 June 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 8 April 1894
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Waterville, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Elmer Stowell — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Mary Brice — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: no record
17. INFORMANT'S OWN SIGNATURE: + Marilyn C. Weaks — ADDRESS: Coulee City, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1519

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 5 weeks.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. *, 19*67*, to* 12 June *, 19*69*, that I last saw the deceased alive on* 12 June *, 19*69*, and that death occurred at* 6:20 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 496 B R Stein M D
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED: 30 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Cremation
24b. DATE: 20 Jun 1969
24c. NAME OF CEMETERY OR CREMATORY: Smith & Co. Crematory
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 7-3-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W E Black — W E Black — LICENSE NO. E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

JUL 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 22 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 12 2000

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2902
Local Reg. No. 182
Reg. Dist. No. 220

Certificate of Death

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nezperce 357
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 17 hrs 417
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Grangeville, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): ELDA
b. (Middle): M
c. (Last): SHEARER

4. DATE OF DEATH (Month) (Day) (Year): June 26, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct 25, 1892
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lineman 09
10b. KIND OF BUSINESS OR INDUSTRY: Washington Water Pow.
11. BIRTHPLACE (State or foreign country): Grangeville, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joel S. Shearer Jr. — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Julia A. Utter — BIRTHPLACE: Williamsburg, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW # 1 3
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: John M. Shearer — ADDRESS: 32-B Vicweg China Lake, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 160 C S Emphasis 1
23b. ADDRESS: 347 St Johns Way Lewiston Idaho
23c. DATE SIGNED: July 7, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/30/69
24c. NAME OF CEMETERY OR CREMATORY: Harpster
24d. LOCATION (City, town, or county) (State): Harpster, Idaho

DATE REC'D BY LOCAL REG.: 7-7-69
REGISTRAR'S SIGNATURE: Glenora Dalzen
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 18 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2903
Local Reg. No. 180
Reg. Dist. No. 320

RECEIVED JUL 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 880
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston, Manor 318

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Asotin 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clarkston
d. STREET ADDRESS (If rural, give location) 2506-6th Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Dick b. (Middle) c. (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year) June 28, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Feb, 5, 1886

9. AGE (In years last birthday) 83
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Farmer 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) E Skane Sweden.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jons Johnson BIRTHPLACE Sweden

14. MOTHER'S MAIDEN NAME Ingrid Heuermann BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO. 4369

17. INFORMANT'S OWN SIGNATURE Donald R. Johnson ADDRESS Clarkston, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-26-, 1969, *to* 6-28-, 1969, *that I last saw the deceased alive on* 6-27-, 1969, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Glenn Cochrane MD

23b. ADDRESS Lewiston

23c. DATE SIGNED 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE July 3, 1969

24c. NAME OF CEMETERY OR CREMATORY Nez Perce Cemetery

24d. LOCATION (City, town, or county) (State) Nez Perce, Idaho.

DATE REC'D BY LOCAL REG. 7-2-69

REGISTRAR'S SIGNATURE Glenna Walgen

25. EMBALMER Andrew F. Vassar

LICENSE NO. E 315

FIRM NAME: Vassar-Rawls Funeral Home.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2904
Local Reg. No. 187
Reg. Dist. No. 220

BIRTH NO.

RECEIVED Bureau of Vital Statistics JUL 7 1969

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN: Lewiston,
c. LENGTH OF STAY IN (this place): 5 days 305
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 216-9th Street

3. NAME OF DECEASED (Type or Print): a. (First) Edward b. (Middle) L c. (Last) Shearer

4. DATE OF DEATH (Month) (Day) (Year): June 29, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: June 9, 1903
9. AGE (In years last birthday): 66 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): barber 21
10b. KIND OF BUSINESS OR INDUSTRY: barber
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: no record — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 501 07 3976
17. INFORMANT'S OWN SIGNATURE: Mrs E. D. Shearer — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Diabetic Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral artery thrombosis, hemiplegia — 4 days
DUE TO (c): Diabetes Mellitus — 16+ mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1968, *to* June, 1969, *that I last saw the deceased alive on* 30 June, 1969, *and that death occurred at* 8:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED: 1 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: July 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: N rmal Hill cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 7-3-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral H me

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2905
Local Reg. No. 14
Reg. Dist. No. 530

Certificate of Death

RECEIVED JUN 30 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Oneida 360
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City
c. LENGTH OF STAY (in this place): 177 life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 194 East 100 North St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Oneida 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City SPOUSE: Alfred V. Edwrd
d. STREET ADDRESS (If rural, give location): 194 East 100 North St.

3. NAME OF DECEASED (Type or Print)
a. (First): VELLA
b. (Middle): THOMAS
c. (Last): EDWARDS

4. DATE OF DEATH (Month) (Day) (Year): JUNE 16, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Sept. 15, 1891
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Logan, Cache, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: RICHARD THOMAS — BIRTHPLACE: Farmington, Utah
14. MOTHER'S MAIDEN NAME: HANNAH PETERSON — BIRTHPLACE: Copenhagen, Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-46-6108
17. INFORMANT'S OWN SIGNATURE: Homer Edwards — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2422

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c): Hyperkyroidism

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on* 6-16, 1969, *and that death occurred at* 2:35p *m., from the causes and on the date stated above.*

23a. SIGNATURE 315 (Degree or title): M.D. 1
23b. ADDRESS: Malad City, Idaho
23c. DATE SIGNED: June 16, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 1
24b. DATE: June 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Malad City Cemetery
24d. LOCATION (City, town, or county) (State): Malad City, Oneida, Idaho

DATE REC'D BY LOCAL REG.: June 17, 1969
REGISTRAR'S SIGNATURE: Ruth G. Sweeten
25. EMBALMER: Raiford G. Benson — LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Benson Funeral Home Malad City, Ida

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 3 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2906
Local Reg. No. 15
Reg. Dist. No. 530

BIRTH NO.

JUN 30 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Oneida 360
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad City
c. LENGTH OF STAY (in this place) 301 one day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Oneida County Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Oneida 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad City SPOUSE: Robert E. Clabby
d. STREET ADDRESS (If rural, give location) 90 West 300 North

3. NAME OF DECEASED (Type or Print) a. (First) GENEVIEVE PEARL b. (Middle) ROBERTSON c. (Last) CLABBY

4. DATE OF DEATH (Month) June (Day) 21 (Year) 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Jan 5 1893

9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY --

11. BIRTHPLACE (State or foreign country) Lake Park, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE WILLIAM T. ROBERTSON, Danville, Quebec, Canada

14. MOTHER'S MAIDEN NAME BIRTHPLACE JESSIE A. HALES Waupun, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) --

16. SOCIAL SECURITY NO. 529-22-5350

17. INFORMANT'S OWN SIGNATURE ADDRESS Don Clabby Salt Lake City, U

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pancreatitis

DUE TO (c) Cholecystitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1967, *to* June 21, 1969, *that I last saw the deceased alive on* June 21, 1969, *and that death occurred at* 11:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Malad City, Idaho

23c. DATE SIGNED June 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE June 24, 1969

24c. NAME OF CEMETERY OR CREMATORY Malad City Cemetery

24d. LOCATION (City, town, or county) (State) Malad City, Idaho

DATE REC'D BY LOCAL REG. June 23, 1969

REGISTRAR'S SIGNATURE Ruth G. Sweeten

25. EMBALMER Rainford G. Benson

LICENSE NO. E-351

FIRM NAME: Benson Funeral Home 132 West 300 Malad City, Id

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 30 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2907
Local Reg. No. 392
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUN 17 1969 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 370 Owyhee

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Duck Valley Res.

c. LENGTH OF STAY (in this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Miller Creek District 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Owyhee 370

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Indian Reservation (Duck Val)

d. STREET ADDRESS (If rural, give location): Owyhhe, Nevada

3. NAME OF DECEASED (Type or Print)

a. (First): Opert

b. (Middle): NMN

c. (Last): Little

4. DATE OF DEATH (Month) (Day) (Year): June 2 1969

5. SEX: Male

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Approx. 1897

9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Ranching

11. BIRTHPLACE (State or foreign country): Nevada

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Sam Little — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Lena Thomas — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 530-14-0029

17. INFORMANT'S OWN SIGNATURE: Medical Records — ADDRESS: Indian Hosp. Owyhee, Nev.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

401X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Natural Causes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Long Standing Ess. Hypertension

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Natural Cause

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): At Home in Garden

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Miller Creek Owyhee Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 2 1969 10a

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Deceased was found in his garden.

22. *I hereby certify that I ~~attended the deceased from~~ investigation only, ~~19~~, to June 2, 1969, that I ~~last saw~~ did not see the deceased alive on June 2, 1969, and that death occurred at 10:00 A.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Andrew Warfield - Coroner 4 583

23b. ADDRESS: Box 366 Homedale, Idaho 83628

23c. DATE SIGNED: June 10, '69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: June 5, 1969

24c. NAME OF CEMETERY OR CREMATORY: Miller Creek Cemetery

24d. LOCATION (City, town, or county) (State): Miller Creek Idaho

DATE REC'D BY LOCAL REG.: 6-10-69

REGISTRAR'S SIGNATURE: Andrew Warfield

25. EMBALMER: Cared for by the Family according to

LICENSE NO.

FIRM NAME: Tribal custom.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2908
Local Reg. No. 199
Reg. Dist. No. 330

RECEIVED JUN 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural New Plymouth
LENGTH OF STAY (in this place) 100 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route #2, N of City 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location) Route #2, N of City

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	OTTO	JOHN	NEUTZE	June	4,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	February 3, 1880	89	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Own Farm	Neche, North Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ed. Neutze	Germany	Amina Herisch	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— —	519-42-2302	Raymond Neutze	Anderson, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic, ischemic myocardial decompensation, 6 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) with Chronic pulmonary edema Chronic arteriosclerotic heart disease 10 yrs

DUE TO (c) Generalized arteriosclerosis & senility 10 to 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 21, 19 69, *to* June 4, 19 69, *that I last saw the deceased alive on* June 4 69, 19 ___, *and that death occurred at* 8:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
/s/ Lee E. Davis M.D. M. D.	New Plymouth, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 7, 1969	Park View Cemetery	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-18-69	Dorothea Anderson	Keith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2909
Local Reg. No. 128
Reg. Dist. No. 330

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 307 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 In Amb. enroute to Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 618 North 5th Street

3. NAME OF DECEASED (Type or Print)
a. (First) Carma Cloraine
b. (Middle)
c. (Last) Bell

4. DATE OF DEATH (Month) (Day) (Year) June 7, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 3, 1914
9. AGE (In years last birthday) 55 — IF UNDER 1 YEAR Months - Days - IF UNDER 24 HRS. Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Buhl, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew Wilson — BIRTHPLACE Nebraska
14. MOTHER'S MAIDEN NAME Annie Slack — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) - - 0 - - -
16. SOCIAL SECURITY NO. 518-09-7265
17. INFORMANT'S OWN SIGNATURE Ray Bell — ADDRESS 618 N. 6th St. Payette, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Self-Inflicted Gunshot Wound — INTERVAL BETWEEN ONSET AND DEATH Unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01
21c. (CITY, TOWN, OR TOWNSHIP) Payette 13 — (COUNTY) Payette 380 — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 7, 1969 Unknown
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Self-Inflicted Gunshot wound through lower left thoracic region

22. *I hereby certify that I* ~~attended the deceased from~~ Investigated, to June 7, 1969 ~~xxxxxxxxxx~~ *the deceased* ~~xxxxxxxxxxxxxxxxxxxx~~, *and that death occurred at* 7:00PM *, from the causes and on the date stated above.*

23a. SIGNATURE Hardy Harkson 583 — (Degree or title) Coroner 4
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 6/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial
24b. DATE 6/9/69
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) Buhl — (State) Idaho

DATE REC'D BY LOCAL REG. 7-14-69
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Marvin R. Heikkila — LICENSE NO. E-515

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer-Jensen Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2910
Local Reg. No. 130
Reg. Dist. No. 330

RECEIVED
JUN 23 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette (Rural)
LENGTH OF STAY (in this place) Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Washoe - Route #1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Payette
d. STREET ADDRESS (If rural, give location) Washoe - Route #1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	HAZEL	FAYE	LINDER

4. DATE OF DEATH: June 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	February 19, 1905	64	---	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Westfall — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Margaret Kurl — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - 9 19X
16. SOCIAL SECURITY NO. 519-22-4758
17. INFORMANT'S OWN SIGNATURE Thomas H. Linder ADDRESS Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of brain and met astases

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1 year

19a. DATE OF OPERATION: Sept 68
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of brain Sept. 68
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 68, 19___, *to* 6-10-, 19 69 *that I last saw the deceased alive on* 5-29-69 19___, *and that death occurred at* 3:45P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 574	M.D.	Payette, Idaho	6-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-13-1969	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-18-69	Donald Anderson	Keith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 5 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2911
Local Reg. No. 121
Reg. Dist. No. 330

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUN 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Parma
c. LENGTH OF STAY (In this place) 110 10yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) RFD 2 Parma 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Parma
d. STREET ADDRESS (If rural, give location) RFD 2 Parma

3. NAME OF DECEASED (Type or Print)
a. (First) Clifford
b. (Middle) Edward
c. (Last) Mitchell

4. DATE OF DEATH (Month) (Day) (Year) 6-10-1969

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 2-12-1917
9. AGE (In years last birthday) 52 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Mitchell — BIRTHPLACE Oklahoma
14. MOTHER'S MAIDEN NAME Bertha Goff — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1 — (If yes, give war or dates of service) War 2 4
16. SOCIAL SECURITY NO. 555-14-4121
17. INFORMANT'S OWN SIGNATURE Virginia Mitchell — ADDRESS RFD 2 Parma Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis, General — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 10, 1969, *to* _____, 19__, *that I last saw the deceased alive on* June 10, 1969, *and that death occurred at* 4:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE 682 (Degree or title) B A Danford, M.D.
23b. ADDRESS Nyssa, Oregon
23c. DATE SIGNED 6-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-14-1969
24c. NAME OF CEMETERY OR CREMATORY Parma
24d. LOCATION (City, town, or county) (State) Parma Idaho

DATE REC'D BY LOCAL REG. 6-18-69
REGISTRAR'S SIGNATURE Annabel Anderson
25. FUNERAL DIRECTOR B B Kirkbaumer #385 — ADDRESS Nyssa Oregon

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 2912
Local Reg. No. 118
Reg. Dist. No. 330

BIRTH NO.

RECEIVED JUN 18 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 26 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1215 7th Ave. North 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1215 7th Ave. North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	None	Wheat	June	10	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 22, 1883	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Winterset, Iowa	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Wheat	Unknown	Janie Lockridge	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	No 0	519-28-3283	* Della I. Wheat	1215 7th Aven Payette Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease with congestive failure — years
DUE TO (c) — 1 mo

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Senility Osteoarthritis of hip.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1958, 19____, *to* 6-10-69 19____, *that I last saw the deceased alive on* 6-5-69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 574	Payette, Idaho	6-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 13, 1969	Rosedale Memorial Gdns	Payette Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-13-69	[signature]	Donald F. Brown	F 408

FIRM NAME: Chapel of The Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated; and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2913
Local Reg. No. 122
Reg. Dist. No. 330

Certificate of Death

RECEIVED
JUN 23 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
STAY (in this place): 3 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ontario
d. STREET ADDRESS (If rural, give location): 578 N.W. 1st, Apt. #10

3. NAME OF DECEASED (Type or Print)
a. (First): AIMA
b. (Middle): WELLS
c. (Last): FULLER

4. DATE OF DEATH (Month) (Day) (Year): June 14, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 6, 1893
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Laurens, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Cartwright — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Maria Sutter — BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): -0
16. SOCIAL SECURITY NO.: 518-38-5068
17. INFORMANT'S OWN SIGNATURE: Geraldine N. Davies — ADDRESS: Ontario, Ore.

4319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized atherosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1959, *19*__, *to* June 14, *19*69, *that I last saw the deceased alive on* June 13, *19*69, *and that death occurred at* 10:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE 553 Thomas W Walth Jr (Degree or title): M.D.
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6-16-1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: 6-18-69
REGISTRAR'S SIGNATURE: Donald Anderson
25. EMBALMER: Keith M. Jensen — LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2914
Local Reg. No. 123
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED
JUN 25 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 7 Yrs. 107
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 529 N 7th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 529 N 7th

3. NAME OF DECEASED (Type or Print)
a. (First): Della
b. (Middle): Rene
c. (Last): Jimerson

4. DATE OF DEATH (Month) June (Day) 19 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 5, 1921
9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: V. S. McKnight — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Iola Chriner — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 541-38-4681
17. INFORMANT'S OWN SIGNATURE: X Earl Jimerson — ADDRESS: Payette, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver (alcoholic) and ascites — INTERVAL BETWEEN ONSET AND DEATH: 2½ years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27, 67, *to* 6-19-69, 19__, *that I last saw the deceased alive on* 6-6-69, 19__, *and that death occurred at* 11:10a *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 574 (Degree or title)
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 6-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/23/69
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county): Payette — (State): Idaho

DATE REC'D BY LOCAL REG.: 6-24-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Donald F Brown
LICENSE NO.: E-408

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Chapel of the Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 1 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2915
Local Reg. No. 127
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
LENGTH OF STAY (in this place) 37 yrs. 137
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 418 N 10th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Carmine	(none)	Fenicottero	June	24,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	July 16, 1889	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mill Worker 06	Mill Worker	Voghera, Italy	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 8 3423X	518-10-1348	Virginia Segety	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Parkinsonism — years
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1963 *, 19 , to* June 24, 1969 *, that I last saw the deceased alive on* 6-21-69 *, 19 , and that death occurred at* 5:25p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Payette, Ida.	6-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 27, 1969	Rosedale Memorial Gardens	Payette, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-27-69	[signature]	Donald F. Bowen	E-408

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Chapel of the Roses

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUL 3 1969

STATE OF IDAHO

State File No. 2916
Local Reg. No. 12
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN: Payette
c. LENGTH OF STAY IN THIS PLACE: 6 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1816 1st Ave. South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JULIA	ELIZABETH	KNORNSCHILD	June	25,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	April 28, 1884	85	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Point Pleasant, West Virginia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Spencer Gregg	Ohio	Tabiatha Ann McNaill	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	— 6	519-22-4898 T	Margaret K Barker	Payette, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Metastatic Carcinoma	5 months
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Gastric Carcinoma	5 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 7, 19 69, *to* June 25, 19 69, *that I last saw the deceased alive on* June 3, 19 69, *and that death occurred at* 3:50P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. H. Arnold 082	M.D.	Payette, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-30-1969	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-2-69	Annabel Anderson	Keith M Jensen	E-517

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

JUL 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUN 18 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2917
Local Reg. No. 32
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
LENGTH OF STAY (in this place) 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) LULA
b. (Middle) BELL
c. (Last) ABERCROMBIE

4. DATE OF DEATH (Month) (Day) (Year) June 11, 1969

5. SEX female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Sept. 17, 1905

9. AGE (In years last birthday) 63
IF UNDER 1 YEAR: Months 8 Days 24
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Oklahoma City, Oklahoma

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph R. Ross
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Nora Bell Jump
BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) 2

16. SOCIAL SECURITY NO. 519-26-2946

17. INFORMANT'S OWN SIGNATURE Ralph A Bell
ADDRESS Aberdeen, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Failure — 3 to 4 weeks
DUE TO (c) Asthma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-4- , 19 68 , *to* 6-11 , 19 69 , *that I last saw the deceased alive on* 6-11- , 19 69 , *and that death occurred at* 12:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE 255 T. A. Anderson (Degree or title)

23b. ADDRESS American Falls, Idaho 83211

23c. DATE SIGNED 6-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial

24b. DATE 6-14-69

24c. NAME OF CEMETERY OR CREMATORY Aberdeen Cemetery

24d. LOCATION (City, town, or county) Aberdeen, (State) Idaho

DATE REC'D BY LOCAL REG. 6-16-69

REGISTRAR'S SIGNATURE Irene Deeg

25. EMBALMER H. L. Davis

LICENSE NO. E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUN 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2918
Local Reg. No. 33
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED JUN 20 1969 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Power 39 | 305

b. CITY OR TOWN: American Falls | c. LENGTH OF STAY IN THIS PLACE: 5 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho | b. COUNTY: Bingham 060

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NETTIE	C.	CORNFORTH	June 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	Cauc.	Married 3	May 14, 1889	80	1	0		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	So. Jordon, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Soren J. Nielsen	Denmark	Karen Sorsensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	519-01-6032	Leonard S. Cornforth	Aberdeen, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrage 4319

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-9-, 1969, *to* 6-14-, 1969, *that I last saw the deceased alive on* 6-14-69, 19____, *and that death occurred at* 11:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
255 T. A. Hunt MD	American Falls, Idaho 83211	6-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	6-17-69	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-19-69	Irene Dilley	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUN 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-192 BIRTH NO.

RECEIVED JUL 3 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2919
Local Reg. No. 36
Reg. Dist. No. 500-602

1. PLACE OF DEATH
a. COUNTY: Power 390 — 306
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL--Michaud Creek
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL--Michaud Creek
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) SANDY b. (Middle) LYNN c. (Last) HANSEN

4. DATE OF DEATH (Month) June (Day) 16 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married /
8. DATE OF BIRTH: Jan. 17, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 6 Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred J. Hansen — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Florence Dusenbery — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 2 No (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Fred J Hansen — ADDRESS: Pocatello

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden death syndrome — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

795X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible] *saw the deceased dead on* June 16, 19 69, *and that death occurred at* 8:15p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Burl Kelly 583 — (Degree or title) Coroner 4
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial /
24b. DATE: Jun 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: 7-2-69
REGISTRAR'S SIGNATURE: Irene Deeg
25. EMBALMER: George W. Knoff — LICENSE NO. 409
FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician *Dr. E. E. Fisher performed the autopsy. Further information concerning "Cause of Death", may be obtained from him.*

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2920
Local Reg. No. 37
Reg. Dist. No. 500-602

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics JUN 27 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Power 390 (203)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
LENGTH OF STAY (in this place): 2½ mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location): 104 Tyler

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	NETTIE	FERN	HEATON		June	17,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Widowed 2	Sept. 3, 1899	69	9	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper 19	Grain Elevator	Oak City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard D. Dutson	Utah	Cornilla Ann Roper	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	8 4319	518-16-5843	Alene Benson	Rockland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-14, 1969, *to* 6-17-, 1969, *that I last saw the deceased alive on* 6-17-69, 19___ *and that death occurred at* 10:10A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
255 I. A. Hunt MD	American Falls, Idaho 83211	6-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-20-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-25-69	Irene Deeg	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2921
Local Reg. No. 37
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED STATE OF IDAHO

JUL 8 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Power 390 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (In this place): 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) H. c. (Last) FRIESEN

4. DATE OF DEATH: (Month) June (Day) 26, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Mar. 2, 1882

9. AGE (In years last birthday): 87 IF UNDER 1 YEAR Months: 3 Days: 24 IF UNDER 24 HRS. Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Hillsboro, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry B. Friesen BIRTHPLACE: Russia

14. MOTHER'S MAIDEN NAME: Helena Duerksen BIRTHPLACE: Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-01-6577

17. INFORMANT'S OWN SIGNATURE: Wilmer J. Friesen ADDRESS: Am. Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Vascular collapse — INTERVAL BETWEEN ONSET AND DEATH: 1 da.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) debility
DUE TO (c) dry gangrene left toes — 2 months

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerosis — 10 years; Intermittent bleeding from G. I. Tract

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April, 1946, *to* June 26, 1969, *that I last saw the deceased alive on* June 26, 1969, *and that death occurred at* 3:15 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 203 F. L. Harris MD

23b. ADDRESS: 213 Idaho Street American Falls, Idaho

23c. DATE SIGNED: 7-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial

24b. DATE: 6-30-69

24c. NAME OF CEMETERY OR CREMATORY: Homestead Cemetery

24d. LOCATION (City, town, or county) (State): Aberdeen, Idaho

DATE REC'D BY LOCAL REG.: July 5, 1969

REGISTRAR'S SIGNATURE: Irene Deeg

25. EMBALMER: H. L. Davis LICENSE NO.: E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2922
Local Reg. No. 35
Reg. Dist. No. 500-602

RECEIVED JUL 2 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location) 209 Idaho St.

3. NAME OF DECEASED (Type or Print)
a. (First) ROSS
b. (Middle) LLOYD
c. (Last) HOLCOMB

4. DATE OF DEATH (Month) (Day) (Year) June 26, 1969

5. SEX Male

6. COLOR OR RACE Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 20, 1894

9. AGE (In years last birthday) 74
IF UNDER 1 YEAR: Months 11 Days 6
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale distributor

10b. KIND OF BUSINESS OR INDUSTRY Wescott Oil Co.

11. BIRTHPLACE (State or foreign country) Marion, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Holcomb
BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Myra Northup
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-09-3287

17. INFORMANT'S OWN SIGNATURE Irma Holcomb
ADDRESS Am. Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peripheral vascular collapse — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Secondary anemia & urinary infection — 2 wk

DUE TO (c) Prostatic resection & pyuria — 1 Mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Severe osteoarthritis — 5 years
Generalized arteriolarsclerosis — 5 years

19a. DATE OF OPERATION May

19b. MAJOR FINDINGS OF OPERATION Prostatic resection for prostatic obstruction

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 19 68, *to* June 26, 1969, *that I last saw the deceased alive on* June 25, 1969, *and that death occurred at* 7:50 A m., *from the causes and on the date stated above.*

23a. SIGNATURE R. L. Harris (Degree or title) MD

23b. ADDRESS American Falls, Idaho

23c. DATE SIGNED 27 June '69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6-28-69

24c. NAME OF CEMETERY OR CREMATORY Fallsview Cemetery

24d. LOCATION (City, town, or county) (State) American Falls, Idaho

DATE REC'D BY LOCAL REG. 6-30-69

REGISTRAR'S SIGNATURE Irene Deeg

25. EMBALMER H. L. Davis

LICENSE NO. E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUL 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2923
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

RECEIVED JUN 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 500
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Kellogg
Statistical DURATION OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. W. Shoshone Gen.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Montana 37 b. COUNTY Lake 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Ronan
d. STREET ADDRESS (If rural, give location) Rt. 2 Ronan, Montana

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Maxime	Jay	Andrew	June 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White-Ind.	Never Married	Oct. 11, 1945	23				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	St. Ignatius, Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew Andrew	Montana	Harriet Beaverhead	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no. 2 None	492-50-0559	Mrs. Josephine Beaverhead	

9259

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Electrocution — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg.) Power Plant
21c. (CITY, TOWN, OR TOWNSHIP) Kellogg (COUNTY) Shoshone (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 6-1-69 about 8:49 P.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Came in contact with electricity

22. *I hereby certify that I attended the deceased from* 6-1, 1969, *to* 6-1, 1969, *that I last saw the deceased alive on* 6-1, 1969, *and that death occurred at* 8:49 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. M. Peterson, M.D.	Wallace, Idaho	6-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	6/3/69	Calgary Cemetery	Ronan Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-23-69			E-520

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2924
Local Reg. No. 145
Reg. Dist. No. 140

RECEIVED JUN 11 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) E. Shoshone Gen. Hosp. 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) West of Kellogg

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Thomas	Riffle	June 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 30, 1897	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor 11	Contracting	Oconto, Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elton Riffle	Unobtainable	Julia Parker	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 2	None 0	519-18-2344	X Mrs W. T. Riffle	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic cardiovascular disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchial asthma — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from early 69, to 4 June, 19 69, that I last saw the deceased alive on 4 June 19 69, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
435 Kent Kennell md	Wallace Idaho	6/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/9/1969	Shoshone Mem. Gardens	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 7 1969	Nels Connell	Merrell K Connell	E-518

FIRM NAME: Mansel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021 (Rev. D. 1)

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 12 1969

JUL 13 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 04 1991

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2925
Local Reg. No.
Reg. Dist. No.

Certificate of Death

BIRTH NO. 69-4074

RECEIVED STATE OF IDAHO

JUL 15 1969

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 401 Shoshone 500

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg

c. LENGTH OF STAY (in this place) minutes

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone 141 Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY Shoshone 400

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)

a. (First) RANDALL

b. (Middle) RAY

c. (Last) ROSSON

4. DATE OF DEATH (Month) (Day) (Year) June 4, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH April 4, 1969

9. AGE (In years last birthday) IF UNDER 1 YEAR Months 2 Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked 02

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Kellogg, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ronald Ray Rosson BIRTHPLACE California

14. MOTHER'S MAIDEN NAME Sheila Bushnell BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) --- 0

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE X Ronald R. Rosson ADDRESS Osburn, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7969

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) "Crib death" unexplained cause — INTERVAL BETWEEN ONSET AND DEATH —

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/4, 1969 only *to* _____, 19__, *that I last saw the deceased alive on* did not see alive, 19__, *and that death occurred at* about 8 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Keith Dahlberg 811 (Degree or title) MD

23b. ADDRESS 204 Oregon St Kellogg

23c. DATE SIGNED 6/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 7, 1969

24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery

24d. LOCATION (City, town, or county) (State) Kellogg, Idaho

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE Joe Irvine

25. EMBALMER Dean O. Petersen

LICENSE NO. E-534

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Maisel Funeral Chapel

DUTIES: JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2926
Local Reg. No. 146
Reg. Dist. No. 140

RECEIVED JUN 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 408
b. CITY OR TOWN: Silverton
c. LENGTH OF STAY (in this place): 800
d. FULL NAME OF HOSPITAL OR INSTITUTION: East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN: Osburn
d. STREET ADDRESS (If rural, give location): 1245 Garden Ave. Silverton, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Angello		Condotta	June	6	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	2-19-1895	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
R.R. Section Foreman 10	Railroad	Istrana, Italy	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable		Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War I 4310	701-01-6612	Mrs. Angela Condotta	Osburn, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6½ days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis & hypertension — Several years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1946, *to* 6-6, 1969, *that I last saw the deceased alive on* 6-6, 1969, *and that death occurred at* 3:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. M. Peterson, M.D.	Wallace, Idaho	6-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 9, 1969	St. Thomas Cemetery	Couer d'Alene Idaho 83814

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 13, 1969	Nile Cornell	Derrell J. Juelfs	E - 518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2927
Local Reg. No. 147
Reg. Dist. No. 14c

RECEIVED JUN 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone Co. Nursing Home 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) — a. (First) John — b. (Middle) Russell — c. (Last) Peterson

4. DATE OF DEATH (Month) (Day) (Year) June 8 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH December 6, 1902

9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mining 07

10b. KIND OF BUSINESS OR INDUSTRY Mines

11. BIRTHPLACE (State or foreign country) Isanti, Minnesota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME — BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service) 3

16. SOCIAL SECURITY NO. 472-07-2175

17. INFORMANT'S OWN SIGNATURE — ADDRESS Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular failure secondary — INTERVAL BETWEEN ONSET AND DEATH 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive Cardiovascular Renal Disease — Several years

DUE TO (c) Aneurysm of aorta
Cerebral hemorrhages
Silicosis
Arthritis of spine, both feet, hands & knees

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

404X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-1, 1946, *to* 6-8-, 1969, *that I last saw the deceased alive on* 6-8, 1969, *and that death occurred at* 12:46 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) H. M. Peterson, M.D.

23b. ADDRESS Wallace Idaho

23c. DATE SIGNED 6-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE June 12, 1969

24c. NAME OF CEMETERY OR CREMATORY Smith Funeral Home

24d. LOCATION (City, town, or county) (State) Spokane Washington

DATE REC'D BY LOCAL REG. June 12, 1969

REGISTRAR'S SIGNATURE Dale Farnell

25. EMBALMER Cornell's Ward Funeral Home

LICENSE NO. E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 1 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

69-5185

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2928
Local Reg. No.
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 401 JUL 15 1969 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Kellogg
c. LENGTH OF STAY (In this place) 20 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp.

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) West Shoshone Gen. Hosp.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Randy	Dean	Nowlin	June 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	May 20, 1969			20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	None	Kellogg, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert D. Robinson	Kansas	Lynda Kincheloe	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	None	None	x Lynda Nowlin	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) probable cerebral damage — INTERVAL BETWEEN ONSET AND DEATH: 1 - 2 days estimated

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) precipitate delivery — 3 wks
DUE TO (c) prematurity

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6/5, 1969, to 6/9, 1969, that I last saw the deceased alive on 6/8, 1969, and that death occurred at 5:30 a. m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gil Leith Dahlberg	M.D.	204 Oregon St Kellogg	6/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/11/69	Shoshone Mem. Gardens	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Joe Dennis	Russell Maisel	E 520

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2929
Local Reg. No. 148
Reg. Dist. No. 140

RECEIVED JUN 18 1969 Bureau of Vital Statistics STATE OF IDAHO

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osburn
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home-410 Mullan Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osburn
d. STREET ADDRESS (If rural, give location): 410 Mullan Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bengt	Victor	Carlson	June	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Dec. 2, 1887					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Blacksmith 07	Mines	Skona, Sweden	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	518-03-9334	Mrs. Clan Carlson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart disease — Interval between onset and death: 4 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-12-69, 19___, *to* 6-13-69, 19___, *that I last saw the deceased alive on* 5-12-69, 19___, *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Box 200 Wallace, Idaho	6-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-18-69	Riverview Cemetery	Kennewick, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 17 1969	[signature]	Derrell J. Juelfs	E - 518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUN 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2930
Local Reg. No.
Reg. Dist. No. 142

BIRTH NO.

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 400
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (If not in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): County Infirmary 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pine Creek
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): EDOR
b. (Middle): LAMBERT
c. (Last): HOJEM

4. DATE OF DEATH (Month) (Day) (Year): June 13, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Feb. 20, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: agriculture
11. BIRTHPLACE (State or foreign country): Irene, South Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ove Hojem — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Karen Rieton — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 3 — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 504-10-5767
17. INFORMANT'S OWN SIGNATURE: X Glenn C. Hojem — ADDRESS:

18. CAUSE OF DEATH 4409
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c) Arteriosclerotic changes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1965, *to* June 13, 1969, *that I last saw the deceased alive on* June 10, 1969, *and that death occurred at* 9:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 052 (Degree or title): [signature] Bourbaka MD
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 25 - June - 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Rem.
24b. DATE: June 19, 69
24c. NAME OF CEMETERY OR CREMATORY: Trondhjem, Cemetery
24d. LOCATION (City, town, or county) (State): Yankton, South Dakota

DATE REC'D BY LOCAL REG.: 7/10/69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Dean H. Peterson — LICENSE NO. E-534
FIRM NAME: Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

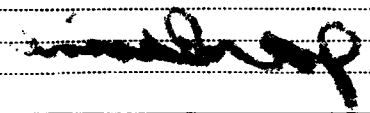

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 2931
Local Reg. No. 147
Reg. Dist. No. 140

BIRTH NO.

RECEIVED STATE OF IDAHO

JUN 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 401
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27
b. COUNTY: Yellowstone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Billings 555
d. STREET ADDRESS (If rural, give location): 120 North 23rd Street

3. NAME OF DECEASED (Type or Print)
a. (First): Elizabeth
b. (Middle): Beryl
c. (Last): Shaffer

4. DATE OF DEATH (Month) (Day) (Year): June 14, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 10, 1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Logansport, Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 517-01-2623
17. INFORMANT'S OWN SIGNATURE: x Jean Goldstein — ADDRESS:

18. CAUSE OF DEATH 4419
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): —
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* April 1, 1969, *to* June 14, 1969, *that I last saw the deceased alive on* June 14, 1969, *and that death occurred at* 2:05 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 052 Bowlbaker MD
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: June 18, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountview Cemetery
24d. LOCATION (City, town, or county) (State): Billings, Montana

DATE REC'D BY LOCAL REG.: 6-24-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Derrel J. Juelfs
LICENSE NO.: E-518

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

DUTIES:

OCT 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2932
Local Reg. No. 150
Reg. Dist. No. 140

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUN 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace 402
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Charles
c. (Last): Mahoney

4. DATE OF DEATH (Month) (Day) (Year): June 23, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 29, 1912
9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Owner 22
10b. KIND OF BUSINESS OR INDUSTRY: Tavern
11. BIRTHPLACE (State or foreign country): Burke, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael Mahoney — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Geraldine Fisher — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 3 — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 536-07-4215
17. INFORMANT'S OWN SIGNATURE: Lucile Mahoney — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: Hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes mellitus — years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-7-61, 19__, *to* 6-23-69, 19__, *that I last saw the deceased alive on* 6-23-69, 19__, *and that death occurred at* 2:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. E. Meidinger MD 182
23b. ADDRESS: Box 200 Wallace, Idaho
23c. DATE SIGNED: 6-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 26, 1969
24c. NAME OF CEMETERY OR CREMATORY: Nine Mile Cemetery
24d. LOCATION (City, town, or county) (State): Wallace, Idaho

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: Dale L. Cornell
25. EMBALMER: Derrell J. Jewelgs — LICENSE NO.: E-518

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 1 0 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 31 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2933
Local Reg. No. 153
Reg. Dist. No. 140

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 400 JUL 15 1969
a. COUNTY Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Calder
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) Unknown
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Milwaukee R.R. Bunk Car

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE WASHINGTON 48
b. COUNTY PIERCE 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TACOMA
d. STREET ADDRESS (If rural, give location) 6527 -93rd Street S. W.

3. NAME OF DECEASED (Type or Print)
a. (First) ROBERT
b. (Middle) PHILLIP
c. (Last) HILL

4. DATE OF DEATH (Month) 6 (Day) 28 (Year) 1969

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED 1
8. DATE OF BIRTH 5/1/1948
9. AGE (In years last birthday) 21 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR 10
10b. KIND OF BUSINESS OR INDUSTRY MILWAUKEE RAILWAY
11. BIRTHPLACE (State or foreign country) TACOMA, WASHINGTON
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME THEODORE HILL (DECEASED) BIRTHPLACE No Data
14. MOTHER'S MAIDEN NAME VERNITA KENNEDY BIRTHPLACE No Data

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 532-50-9321
17. INFORMANT'S OWN SIGNATURE Vernita Hill ADDRESS 6527-93rd S.W. Tacoma Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3459

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) & Edema secondary to
DUE TO (c) Epileptic Seizure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-28, 1969, *to* 6-28, 1969, *that I last saw the deceased alive on* 6-28, 1969, *and that death occurred at* about 4:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 414 G. M. Peterson, M.D. (Degree or title)
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 6-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE June 30, 1969
24c. NAME OF CEMETERY OR CREMATORY -Buckley-King Funeral Home, Tacoma, Wash.
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. July 10, 1969
REGISTRAR'S SIGNATURE Dale Hornell
25. EMBALMER Gerald E Browning
LICENSE NO. E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 12 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2934
Local Reg. No. 7
Reg. Dist. No. 620

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUN 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (In this place): 1 month 201
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tetonia
d. STREET ADDRESS (If rural, give location): none given

3. NAME OF DECEASED (Type or Print)
a. (First): RICHARD
b. (Middle): E.
c. (Last): MURRAY

4. DATE OF DEATH (Month) (Day) (Year): June 5, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Nov 13, 1892
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder 21
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Vernal, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Ellison Murray — BIRTHPLACE: Spanish Fork, Utah
14. MOTHER'S MAIDEN NAME: Carrie Marie Jensen — BIRTHPLACE: Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes 1 — (If yes, give war or dates of service): WW1 3
16. SOCIAL SECURITY NO.: 529-01-6997
17. INFORMANT'S OWN SIGNATURE: x Marian Phillips — ADDRESS: Tetonia, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3039

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Manitou — INTERVAL BETWEEN ONSET AND DEATH: 4 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): COPE — 10 years
~~DUE TO (c)~~ and Alcoholism

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Ca of Prostate

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1961, *to* 6-5, 1969, *that I last saw the deceased alive on* 6-5, 1969, *and that death occurred at* 7:21a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 219 K Head MD
23b. ADDRESS: Driggs Idaho
23c. DATE SIGNED: 6-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Cache-Clawson Cemetery
24d. LOCATION (City, town, or county) (State): Tetonia, Teton Co., Idaho

DATE REC'D BY LOCAL REG.: 6-10-69
REGISTRAR'S SIGNATURE: Ella Griggs
25. EMBALMER: Robert Bean
LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robert Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 23 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2935
Local Reg. No. 8
Reg. Dist. No. 620

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Teton 410 JUN 18 1969 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Driggs
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 2½ Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Herman Hastings Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Driggs
d. STREET ADDRESS (If rural, give location) R.F.D. Near Driggs

3. NAME OF DECEASED (Type or Print) a. (First) ERMA b. (Middle) JEAN HOCHSTRASSER c. (Last) PEACOCK

4. DATE OF DEATH (Month) (Day) (Year) June 10, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 28 Oct. 1888
9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY ———
11. BIRTHPLACE (State or foreign country) Providence, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Nephi William Hochstrasser BIRTHPLACE S. L. City, Ut.
14. MOTHER'S MAIDEN NAME Jane Fullmer BIRTHPLACE S. L. City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0 ———
16. SOCIAL SECURITY NO. 543-28-5525
17. INFORMANT'S OWN SIGNATURE Cassie Hastings ADDRESS Driggs, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Advanced Senility — 5 years
DUE TO (c) Arteriosclerosis — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ca of bowel 12 y ago removed c̄ Surgery

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 9, 1961, *to* June 9, 1969, *that I last saw the deceased alive on* June 9, 1969, *and that death occurred at* 7:15A. *m., from the causes and on the date stated above.*

23a. SIGNATURE 219 [signature] (Degree or title) M. D.
23b. ADDRESS Driggs, Idaho
23c. DATE SIGNED 6-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 13 June 1969
24c. NAME OF CEMETERY OR CREMATORY Cache-Clawson Cemetery
24d. LOCATION (City, town, or county) (State) Tetonia, Teton Co., Idaho

DATE REC'D BY LOCAL REG. 6-16-69
REGISTRAR'S SIGNATURE Ella Griggs
25. EMBALMER [signature] LICENSE NO. E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 13 1987

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2936
Local Reg. No. D-187
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY JUN 9 1969 Twin Falls 421 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 421
d. STREET ADDRESS (If rural, give location) Heritage Manor

3. NAME OF DECEASED (Type or Print)
a. (First) ALICE
b. (Middle) PEARL
c. (Last) BROWN

4. DATE OF DEATH (Month) (Day) (Year) June 2, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 17, 1885
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Milledgeville, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Pike — BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Emma Blough — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 518-54-2055
17. INFORMANT'S OWN SIGNATURE Box 229 Charles R Brown Buhl, Idaho — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	Minutes
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic heart disease	Years
DUE TO (c)	Generalized Arteriosclerosis	Years
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Vascular accident of small bowel	Hours

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 7, 1969 *to* June 2, 1969, *that I last saw the deceased alive on* March 7, 1969, *and that death occurred at* 6:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 118 C. A. Cullen [signature]
23b. ADDRESS 122 9th Ave. No. Buhl, Idaho
23c. DATE SIGNED 6-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 6/4/69
24c. NAME OF CEMETERY OR CREMATORY Rocklake
24d. LOCATION (City, town, or county) (State) Rocklake, North Dakota

DATE REC'D BY LOCAL REG. June 5, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER George Farmer — LICENSE NO. E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2937
Local Reg. No. D-188
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 JUN 9 1969
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place) 800
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 421
c. CITY OR TOWN Twin Falls 83301
d. STREET ADDRESS (If rural, give location) (DOA) 403 2nd St. No.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES	M.	HOMAN	June 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Widowed 2	July 11, 1893	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 29 Farmer (retired)
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Mark Homan — BIRTHPLACE UNK
14. MOTHER'S MAIDEN NAME UNK — BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. 518-10-3457
17. INFORMANT'S OWN SIGNATURE David Homan — ADDRESS Filer, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema & Coronary pulmonade
DUE TO (c) Tricuspid insufficiency

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES XX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroners Investigation Only *, that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 3:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lloyd O. Edwards 583	Coroner	Twin Falls, Idaho	6/4/1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 6, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 5, 1969	Marva D. Marsh	Edgar J. Robertson	E-507

FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 16 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 2938
Local Reg. No. D-191
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUN 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH — a. COUNTY: Twin Falls 421 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls — LENGTH OF STAY (In this place): 000 — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE: Idaho — b. COUNTY: T.Falls — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 421 — d. STREET ADDRESS (If rural, give location): 304 Walnut Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BETTY	L.	HOYER	June 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	May 15, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laboratory Aide 21	Hospital	Dudley, Penna.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Raymond Greenawalt	Penna.	Flora Eberhart	Penna.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 3	188-07-3341	Jo M. Bartholomew	Jerome, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Giant cell Carcinoma

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) left lung 2 yrs

DUE TO (c) Uremia and toxic

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 1969 *to* 6/31, 1969, *that I last saw the deceased alive on* 5-28, 1969, *and that death occurred at* 2 100 p. m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
460 [illegible] M.D.	Twin Falls, Idaho	6-9-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/6/69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER James C. Reynolds	LICENSE NO.
June 9, 1969	Marva D. Marsh	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 11 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2939
Local Reg. No. D-204
Reg. Dist. No. 460

BIRTH NO JUN 20 1969

1. PLACE OF DEATH
a. COUNTY: Bureau of Vital Statistics Twin Falls 420 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (in this place): 5½ years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 420
d. STREET ADDRESS (If rural, give location): Harral Nursing Home

3. NAME OF DECEASED (Type or Print): a. (First) ROBERT b. (Middle) G. c. (Last) HOFFMAN

4. DATE OF DEATH: (Month) June (Day) 4, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Dec. 17, 1883

9. AGE (In years last birthday): 85
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheep Herder

10b. KIND OF BUSINESS OR INDUSTRY: Livestock

11. BIRTHPLACE (State or foreign country): Woodsbury, Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: No Record
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: No Record
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-24-6075

17. INFORMANT'S OWN SIGNATURE: [signature] Box 349
ADDRESS: Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Congestive Failure (heart) — INTERVAL BETWEEN ONSET AND DEATH: Weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — Years
DUE TO (c): Cor Pulmonale — Weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1, 19 65 *to* June 4, 19 69, *that I last saw the deceased alive on* May 24, 19 69 *and that death occurred at* 12:15 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title)

23b. ADDRESS: 122 9th Ave. No. Buhl, Idaho

23c. DATE SIGNED: 6-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6/7/69

24c. NAME OF CEMETERY OR CREMATORY: Buhl

24d. LOCATION (City, town, or county) (State): Buhl Idaho

DATE REC'D BY LOCAL REG.: June 16, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: George Farmer

LICENSE NO.: E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2940
Local Reg. No. D-201
Reg. Dist. No. 460

RECEIVED JUN 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN Buhl (If outside corporate limits, write RURAL and give township) 203
STAY (in this place) 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN Buhl (If outside corporate limits, write RURAL and give township) 420
d. STREET ADDRESS (If rural, give location) 820 Sprague

3. NAME OF DECEASED (Type or Print) a. (First) Alfred b. (Middle) Paul c. (Last) Diehl

4. DATE OF DEATH (Month) (Day) (Year) June 5, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH June 25, 1880

9. AGE (In years last birthday) 88
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Own Farm

11. BIRTHPLACE (State or foreign country) Marshel Town, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin Luther Diehl
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Louise Fleming
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 2 8

16. SOCIAL SECURITY NO. 518-34-4164

17. INFORMANT'S OWN SIGNATURE X M. P. Diehl ADDRESS Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic heart disease. — years

DUE TO (c) Generalized arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 13, *19*67, *to* June 6, *19*69, *that I last saw the deceased alive on* May 24, *19*69, *and that death occurred at* 10:25p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)

23b. ADDRESS 122 9th Ave. North Buhl, Ida

23c. DATE SIGNED 6-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 9, 1969

24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery

24d. LOCATION (City, town, or county) Buhl (State) Idaho

DATE REC'D BY LOCAL REG. June 12, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER

LICENSE NO. E-482

FIRM NAME Hopkins-Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUN 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2941
Local Reg. No. D-190
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 11 1969 Bureau of Vital Stat.

BIRTH NO.

1. PLACE OF DEATH 431
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 5 days 305
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE New Mexico 32
b. COUNTY McKinley 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Crown Point,
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Janette
b. (Middle)
c. (Last) CHIQUITO

4. DATE OF DEATH (Month) (Day) (Year) June 6, 1969

5. SEX Male
6. COLOR OR RACE Navajo Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH March 3, 1969
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 3 Days 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked 02
10b. KIND OF BUSINESS OR INDUSTRY - - - -
11. BIRTHPLACE (State or foreign country) Crownpoint, New Mexico
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Chee Chiquito BIRTHPLACE New Mexico
14. MOTHER'S MAIDEN NAME Hilda Morgan BIRTHPLACE New Mexino

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) - - 0 - -
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Chee Chiquito ADDRESS Crownpoint, N. Mexico

18. CAUSE OF DEATH 5679
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Sepsis - Probably gram Neg. organism — INTERVAL BETWEEN ONSET AND DEATH 10 dy

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Peritonitis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/2/69, 19__, *to* 6/4/69, 19__, *that I last saw the deceased alive on* 6/4/69, 19__, *and that death occurred at* 9 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Ben [illegible] 274 (Degree or title) MD
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 6/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE June 6, 1969
24c. NAME OF CEMETERY OR CREMATORY Crownpoint Cemetery
24d. LOCATION (City, town, or county) (State) Crownpoint, New Mexico

DATE REC'D BY LOCAL REG. June 9, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Charles H Persons
LICENSE NO. E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2942
Local Reg. No. D-207
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUN 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 420 101
b. CITY OR TOWN Buhl
c. LENGTH OF STAY IN (If outside corporate limits, write RURAL and give township) this place 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1311 Locust St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 420
d. STREET ADDRESS (If rural, give location) 1311 Locust St.

3. NAME OF DECEASED (Type or Print) a. (First) Dallas b. (Middle) J. c. (Last) Foster

4. DATE OF DEATH (Month) (Day) (Year) June 6, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 28, 1906
9. AGE (In years last birthday) 62 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist 21
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin Foster BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Mary Evans BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 541-16-5006
17. INFORMANT'S OWN SIGNATURE Ruth E. Foster ADDRESS Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cor pulmonale — months
DUE TO (c) Pulmonary emphysema — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* May 11, 1964, *to* June 6, 1969, *that I last saw the deceased alive on* May 26, 1969, *and that death occurred at* 5:10 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 118
23b. ADDRESS 122 9th Ave. No. Buhl, Idaho
23c. DATE SIGNED 6-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 11, 1969
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) Buhl (State) Idaho

DATE REC'D BY LOCAL REG. June 18, 1969
REGISTRAR'S SIGNATURE Marna D. Marsh
25. EMBALMER Jim A Hopkins
LICENSE NO. E-482

FIRM NAME Hopkins-Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUN 2 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 2 0 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 4 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2943
Local Reg. No. D-194
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
JUN 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY T.Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 421
d. STREET ADDRESS (If rural, give location) 312 Shoshone Street East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ETHEL	V.	THOMPSON	June 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	January 2, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Claremont, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Andrew	Mt. Vernon, Iowa	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
no 0	579-09-6843D	James C. Reynolds Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis 4100 — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension & Arteriosclerosis
DUE TO (c) Heart Disease — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Subacute Cholecystitis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-6-69	Subacute Cholecystitis & Choledocolithiasis	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 4-10, 19 9, to 6/6/, 19 69, that I last saw the deceased alive on 6/6, 19 69 and that death occurred at 4:50 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George W. Sauer M.D.	Twin Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/9/69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 10, 1969	Marva D. Marsh	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 2944
Local Reg. No. D-199
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
JUN 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ~~Burxix Filer~~ Twin Falls
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY T. Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 420 Rural Filer
d. STREET ADDRESS (If rural, give location) R.R.#2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALFRED	A.	BAILEY	June 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	January 31, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher-Stockman 04		Valentine, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur Bailey	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 3	0	518-22-7984	Mrs Al Bailey	Filer, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) ca of lung. — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* 6/7/, 19 69, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 4:25a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
064 Harry Brumbach Jr. M.D.	Twin Falls, Idaho	6-9-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/10/69	I.O.O.F. Cemetery	Filer, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 11, 1969	Marva D. Marsh	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 12 1969

APR 4 1985

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 2945
Local Reg. No. D-197
Reg. Dist. No. 460

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
JUN 12 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer 83328 420
d. STREET ADDRESS (If rural, give location): 407 Yakima

3. NAME OF DECEASED (Type or Print)
a. (First): HAZEL
b. (Middle): RAE
c. (Last): BOWEN

4. DATE OF DEATH (Month) (Day) (Year): June 7, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: July 20, 1918
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaking
11. BIRTHPLACE (State or foreign country): Filer, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Felix Turnipseed — BIRTHPLACE: Mississippi
14. MOTHER'S MAIDEN NAME: Retta Cox — BIRTHPLACE: No. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): ---- 0
16. SOCIAL SECURITY NO.: 519-16-3694
17. INFORMANT'S OWN SIGNATURE: x James A. Bowen — ADDRESS: Filer, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemopneumothorax & Basal skull fracture - brain stem contusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 45

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): XX 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Filer, Twin Falls, Idaho 420
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile Accident

22. *I hereby certify that I attended the deceased from* June 7, 1969, *to* June 7, 1969, *that I last saw the deceased alive on* June 7, 1969, *and that death occurred at* 7:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 064 H Brumbach Jr M.D. 1
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 6/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: June 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Filer IOOF Cemetery
24d. LOCATION (City, town, or county) (State): Filer, Idaho

DATE REC'D BY LOCAL REG.: June 10, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Jerry D. Holman — LICENSE NO.: E-516
FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 9 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 27 1973

MAR 12 1974

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate.

JAN 27 1989

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2946
Local Reg. No. D-262
Reg. Dist. No. 460

RECEIVED
JUN 17 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY IN THIS PLACE 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 420
d. STREET ADDRESS (If rural, give location) 219 Harrison St.

3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) D. c. (Last) PERRY

4. DATE OF DEATH (Month) (Day) (Year) June 7, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH June 23, 1917

9. AGE (In years last birthday) 51
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright 06

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Buist, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ira James Perry
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME Julia H. Hammer
BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW II 1921

16. SOCIAL SECURITY NO. 530-07-0845

17. INFORMANT'S OWN SIGNATURE X Mrs Robert D Perry
ADDRESS Twin Falls,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic carcinoma, left lung
INTERVAL BETWEEN ONSET AND DEATH 6 mo. +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 March, 19 69, *to* 7 June, 19 69, *that I last saw the deceased alive on* 7 June, 19 69, *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 489 James H. Spafford (Degree or title) MD
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 6/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/11/69
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. June 13, 1969
REGISTRAR'S SIGNATURE Marian D. Marsh
25. EMBALMER Jerry D. Holman
LICENSE NO. E-516
FIRM NAME White Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2947
Local Reg. No. D - 198
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls — JUN 12 1969
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY in this place 088
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 Magic Valley Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Texas 44
b. COUNTY Hidalgo 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pharr 78577
d. STREET ADDRESS (If rural, give location) 311 West Wright

3. NAME OF DECEASED (Type or Print)
a. (First) REYMUNDO
b. (Middle) E.
c. (Last) RICO

4. DATE OF DEATH (Month) (Day) (Year) June 7, 1969

5. SEX Male

6. COLOR OR RACE Spanish

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Jan. 27, 1945

9. AGE (In years last birthday) 24 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Atanacio H. Rico — BIRTHPLACE Mexico

14. MOTHER'S MAIDEN NAME Margarita Escodeco — BIRTHPLACE Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 | (If yes, give war or dates of service) ----- 0

16. SOCIAL SECURITY NO. 455-68-5550

17. INFORMANT'S OWN SIGNATURE X Atanacio H. Rico — ADDRESS Pharr, Texas

18. CAUSE OF DEATH 8199
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subdural & Subaraclinoid Hemorrhages — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) associated cerebral Contusions
DUE TO (c) Acute Intoxication, Moderate

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hiway 80N. 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jerome County, Idaho 270

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 7, 1969-9:20pm

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR? Auto Accident

22. *I hereby certify that I attended the deceased from* Coroners investigation, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Clopse O. Edwards 583 — (Degree or title) Coroner

23b. ADDRESS R#3 Twinfalls Ida.

23c. DATE SIGNED 6-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1

24b. DATE 6/10/69

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. June 10, 1969

REGISTRAR'S SIGNATURE Mamie D. Marsh

25. EMBALMER Edgar J. Robertson — LICENSE NO. E-507

FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2948
Local Reg. No. D-193
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUN 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH 421
a. COUNTY Twin Falls 412
b. CITY OR TOWN Twin Falls | LENGTH OF STAY (in this place) 12 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hosp 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 421
d. STREET ADDRESS (If rural, give location) 1746 3rd Ave. E.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARY	ALZONA	SNYDER	June 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	white	married 3	Sept. 3, 1882	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 61	own home	Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Fowler	Iowa	Eva Heater	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - -	505-26-6797	Bx M. J. Snyder	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	1½ hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis Cardio Vascular Disease	10+ yrs
DUE TO (c)	Hypertension	9 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus	16+ yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 6, 1969, *to* June 7, 1969, *that I last saw the deceased alive on* June 6, 1969, *and that death occurred at* 1:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward Rees MD 431	Twin Falls Idaho	6-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-10-69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 9, 1969	Marva D. Marsh	Dale C. Patterson	E451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 06 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2949
Local Reg. No. D-195
Reg. Dist. No. 460

BIRTH NO.

RECEIVED STATE OF IDAHO

JUN 12 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 888
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 421
d. STREET ADDRESS (If rural, give location): 515 Buchanan

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) JANET c. (Last) ALLRED

4. DATE OF DEATH (Month) (Day) (Year): June 8, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: June 5, 1902

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 67

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: homemaking

11. BIRTHPLACE (State or foreign country): Heber City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John S. Rooker — BIRTHPLACE: Heber City, Utah

14. MOTHER'S MAIDEN NAME: Jeannette E. Wing — BIRTHPLACE: Heber City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----8

16. SOCIAL SECURITY NO.: 518-42-1302

17. INFORMANT'S OWN SIGNATURE: Mary Allred — ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Thrombosis 4189 — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease 5 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Carcinoma ovary & metastasis 6 mo

19a. DATE OF OPERATION: 1-2-69

19b. MAJOR FINDINGS OF OPERATION: Carcinoma ovary & metastasis

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1969, *to* 6-8, 1969, *that I last saw the deceased alive on* 6-8, 1969, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George W. Warner M.D. 551

23b. ADDRESS: 111 6th Ave E Twin Falls

23c. DATE SIGNED: 6-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6/11/69

24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery

24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: June 10, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: Ruth Bird

LICENSE NO.: E-373

FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2950
Local Reg. No. D-192
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 11 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 3 days 303
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 421
d. STREET ADDRESS (If rural, give location) 1316 East 6th Avenue

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) ROBERT c. (Last) BIXLER

4. DATE OF DEATH (Month) (Day) (Year) June 8, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 15, 1901
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype operator
10b. KIND OF BUSINESS OR INDUSTRY Printing
11. BIRTHPLACE (State or foreign country) St. Paul, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Bixler 21 BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Bessie BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) - - - 0 - - - 2
16. SOCIAL SECURITY NO. 234-05-5077A
17. INFORMANT'S OWN SIGNATURE X Mrs. C. R. Bixler ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4928

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH 15 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 5 1948, *to* June 8, 1969, *that I last saw the deceased alive on* June 7, 1969, *and that death occurred at* 1:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE Dean P. Abbleck (Degree or title) 003
23b. ADDRESS 231 4th Avenue North Twin Falls, Idaho 83301
23c. DATE SIGNED June 9, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-10-69
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. June 9, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER William J. Boyd
LICENSE NO. E-490

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Twin Falls Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
JUN 18 1969
Bureau of Vital Statistics

State of Idaho
County of Twin Falls } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts in the certificate of death (Birth or Death)
for Charles Robert Bixler (Name on Original Certificate) who died (Was Born or Died) on June 8, 1969 (Date of Event)
in Twin Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Birth Record (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Age of deceased	68	67

Subscribed and sworn to before me this 16th day of June 1969

Notary Public, residing at Twin Falls

My commission expires 8-1-70

(Seal)

Signed Mrs. C. R. Bixler
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1316 6th Ave. E, Twin Falls, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Twin Falls } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 16th day of June 1969

Notary Public, residing at Twin Falls

My commission expires 8-1-70

(Seal)

Signed Mary K. Boyd
(Signature of Any Credible Person)

263 2nd Ave. N, Twin Falls, Idaho
(Street Address, City, State)

FORM DH 60-155

JUN 19 1969
SEP 16 1994

Certificate of Death

STATE OF IDAHO

State File No. 2951
Local Reg. No. D-196
Reg. Dist. No. 460

RECEIVED
JUN 12 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 8 66
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Route # 1 420
d. STREET ADDRESS (If rural, give location): Filer 83328

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) W. c. (Last) COLBERT

4. DATE OF DEATH (Month) (Day) (Year): June 8, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Oct. 23, 1904
9. AGE (In years last birthday): 64 (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Colbert — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 537-26-5262
17. INFORMANT'S OWN SIGNATURE: Mary Bean — ADDRESS: Filer, Idaho

340X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): Multiple Infarcts

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 14, 19 69 *to* 6 8, 19 69, *that I last saw the deceased alive on* 6-6-69, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 6/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/11/69
24c. NAME OF CEMETERY OR CREMATORY: Filer IOOF Cemetery
24d. LOCATION (City, town, or county) (State): Filer, Idaho

DATE REC'D BY LOCAL REG.: June 10, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Edgar J. Robertson
LICENSE NO.: E-507
FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2952
Local Reg. No. D-386
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
JUN 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls
b. CITY OR TOWN Buhl
c. LENGTH OF STAY IN CITY 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION 1620 Main St. 000 462

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN Buhl 420
d. STREET ADDRESS (If rural, give location) 1620 Main St.

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) C. c. (Last) Pew

4. DATE OF DEATH (Month) (Day) (Year) June 9, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 9, 1894
9. AGE (In years last birthday) 74 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 84
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Crossville, Tenn
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Pew | BIRTHPLACE Tenn.
14. MOTHER'S MAIDEN NAME Catherine Houston | BIRTHPLACE Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 2
16. SOCIAL SECURITY NO. 519-14-3034
17. INFORMANT'S OWN SIGNATURE X John Pew Jr | ADDRESS Filer, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary Insufficiency — Minutes

DUE TO (c) Arteriosclerotic heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Gloyce O. Edwards 583 (Degree or title) Coroner
23b. ADDRESS R#3 Addison Ave E. Twin Falls
23c. DATE SIGNED 6-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 12, 1969
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. June 18, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Jim A Hopkins | LICENSE NO. E-482

FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2953
Local Reg. No. D-200
Reg. Dist. No. 460

BIRTH NO.

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 — JUN 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 8 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sky View Manor 373 108

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 421
d. STREET ADDRESS (If rural, give location): 640 Filer Avenue West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NANCY	EBBILINE	DAVIS	June 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	Oct. 18, 1875	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 01	Own Home	Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alexander Sutton	Ukn	Nancy M. Harmon	Unkn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	518-60-8978	x Mrs. Frank (Dassie) Eastman	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Occlusion 4709	4 d
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic cardio-vascular disease	20 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 19 67, *to* June, 19 69, *that I last saw the deceased alive on* 9 June, 19 69, *and that death occurred at* 7:05a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Verner H. Kramer M.D.	Twin Falls, Idaho	6-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	June 12, 1969	Union Valley Cemetery	Belleville, Kansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 12, 1969	Maria D. Marsh	Dale L. Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

JUN 2 0 1969

JAN 2 3 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

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IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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ADDITIONAL REMARKS by Physician.....

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State File No. 2954
Local Reg. No. D-209
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO. 69-6344

RECEIVED JUN 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Idaho b. COUNTY Twin Falls 408
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Castleford 421
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First) Ida	b. (Middle) Helen	c. (Last) Runyan	4. DATE OF DEATH (Month) (Day) (Year) June 10, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1	8. DATE OF BIRTH June 10, 1969	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 8 Min. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02	10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles J. Runyan	BIRTHPLACE Nebr..		14. MOTHER'S MAIDEN NAME Helen Hathway	BIRTHPLACE Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2	(If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. None	17. INFORMANT'S OWN SIGNATURE X Charles Runyan	ADDRESS Castleford, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7769

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Twin birth, Premature infant — 1 day

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/10, 1969, *to* 6/10, 1969, *that I last saw the deceased alive on* 6/10, 1969, *and that death occurred at* 6:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE 576 S. M. Wright	(Degree or title) MD 1	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 6/17/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE June 13, 1969	24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery	24d. LOCATION (City, town, or county) (State) Buhl, Idaho
DATE REC'D BY LOCAL REG. June 23, 1969	REGISTRAR'S SIGNATURE Marcia D. Marden	25. EMBALMER Jim A Hopkins	LICENSE NO. E-482

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-6343

BIRTH NO.

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2955
Local Reg. No. D-210
Reg. Dist. No. 460

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls JUN 25 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If in hospital or institution) 9 hrs. 409
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Castleford 420
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Lydia
b. (Middle) Ellen
c. (Last) Runyan

4. DATE OF DEATH (Month) (Day) (Year) June 10, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH June 10, 1969
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 9 Min. 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles J, Runyan BIRTHPLACE Nebr.
14. MOTHER'S MAIDEN NAME Helen Hathway BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Charles Runyan ADDRESS Castleford, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7769

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Immotal atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Premature — 1 day

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/10, 1969, *to* 6/10, 1969, *that I last saw the deceased alive on* 6/10, 1969, *and that death occurred at* 6:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Tom Wright 576 (Degree or title) MD
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 6/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE June 13, 1969
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. June 23, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Jim A Hopkins
LICENSE NO. E-482

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2956
Local Reg. No. D-208
Reg. Dist. No. 460

RECEIVED JUN 20 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN: Twin Falls 301
c. LENGTH OF STAY IN THIS PLACE: 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Mem. Hosp. 148

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: Cache 555
c. CITY OR TOWN: Providence
d. STREET ADDRESS (If rural, give location): [illegible] Idaho

3. NAME OF DECEASED (Type or Print): a. (First) SAMUEL b. (Middle) NEWEL c. (Last) SCHENK

4. DATE OF DEATH: (Month) (Day) (Year) JUNE 10-1969

5. SEX: male

6. COLOR OR RACE: cauc

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married B

8. DATE OF BIRTH: June 23, 1898

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick-Mason 2

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): College Ward, Cache, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frederick Schenk- Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Annie Rebecca Quibell- Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): 8

16. SOCIAL SECURITY NO.: 529-07-3876A

17. INFORMANT'S OWN SIGNATURE: Wesley Schenk - Providence Utah
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute lymphoblastic leukemia
INTERVAL BETWEEN ONSET AND DEATH: 7-8 weeks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-5, 1969, *to* 6-10, 1969, *that I last saw the deceased alive on* 6-9-, 1969, *and that death occurred at* 8:05A m., *from the causes and on the date stated above.*

23a. SIGNATURE George S. Brown MD FACP (Degree or title)

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 6-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6/13/69

24c. NAME OF CEMETERY OR CREMATORY: Providence Cem.

24d. LOCATION (City, town, or county) (State): Providence, Cache Co, Utah

DATE REC'D BY LOCAL REG.: June 18, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: [signature]
LICENSE NO.: E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 2 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 1 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 1 7 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2957
Local Reg. No. D-203
Reg. Dist. No. 460

RECEIVED JUN 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Twin Falls 421 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 — LENGTH OF STAY (in this place): 000 — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho 13 — b. COUNTY: TwinFalls — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 421 — d. STREET ADDRESS (If rural, give location): Valley Nursing Home

3. NAME OF DECEASED (Type or Print) — a. (First): IRMA — b. (Middle): — c. (Last): BROWN

4. DATE OF DEATH — (Month) (Day) (Year): June 11, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 31, 1889

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Brainerd, Minnesota

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Fred Parker — BIRTHPLACE: Wisconsin

14. MOTHER'S MAIDEN NAME: Hattie Parker — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0 4339

16. SOCIAL SECURITY NO.: 477-24-1399

17. INFORMANT'S OWN SIGNATURE: George E. Brown Mrs — ADDRESS: TwinFalls Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebrovascular Thrombosis, Paralysis — INTERVAL BETWEEN ONSET AND DEATH: 3days.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 21, 1956 *to* June 10, 1969, *that I last saw the deceased alive on* June 10, 1969, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B.C. Knibbs M.D. 296 — 23b. ADDRESS: Twin Falls, Idaho — 23c. DATE SIGNED: 6.13.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 6.13.69 — 24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery — 24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: June 13, 1969 — REGISTRAR'S SIGNATURE: Marva D. Marsh — 25. EMBALMER: [signature] — LICENSE NO.: E 343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 5 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2958
Local Reg. No. D-205
Reg. Dist. No. 460

Certificate of Death

RECEIVED
JUN 20 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 431
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF 4 days 304
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hosp. 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eden
d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle):
c. (Last): STEINMETZ Sr.

4. DATE OF DEATH (Month) (Day) (Year): June 11, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Jan. 1, 1880
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming 04
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Baunnanthal, Germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob Steinmetz — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Elizabeth Block — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-46-2608
17. INFORMANT'S OWN SIGNATURE: X Geo. Steinmetz Jr. — ADDRESS: Eden, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Dehydration c̄ Acidosis — 2 weeks
DUE TO (c) Congestive Heart Failure — 24 hrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-13, 1955, *to* 6-11, 1969, *that I last saw the deceased alive on* 6-11, 1969, *and that death occurred at* 8:50 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): D. G. McCushy MD 338 1
23b. ADDRESS: Twin Falls Idaho
23c. DATE SIGNED: 6-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: June 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Park Cem.
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: June 17, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: [signature]
LICENSE NO.: 343

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 7 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2959
Local Reg. No. D-222
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH — County: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (in this place): 26 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00516 North Broadway

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 516 North Broadway

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANN	B.	MC MANAMAN	June 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	Dec. 31, 1909	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Holt County, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Patrick Boyle	Ireland	Ann Matthews	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 4109
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: 115 8th N. Buhl, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infarction of Myocardium — INTERVAL BETWEEN ONSET AND DEATH: 45 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) due to Coronary Sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-12, 1969, about *to* 6-12, 1969, *that I last saw the deceased alive on* June 12, 1969, *and that death occurred at* 4:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H Henderson	MD	Buhl, Ida	June 28, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/16/69	Buhl	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 2, 1969	Marva O. Marsh	George Farmer	E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 1 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2960
Local Reg. No. D-217
Reg. Dist. No. 460

RECEIVED JUN 27 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Buhl
c. If outside limits of Buhl, Bureau of Vital Statistics, STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 420
d. STREET ADDRESS (If rural, give location): Rural Route 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DENNIS	B.	WRIGHT	June 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Dec 20, 1917	51	5	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm laborer 04	agriculture	Middleton, Arkansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Keller Wright	Arkansas	Alice Gage	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes / W.W. 2 4-7	432-22-0763	Bonnie Wright	Buhl

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	INTERVAL BETWEEN ONSET AND DEATH
	Myocardial Infarction	1 hr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Due to coronary thrombosis	
	DUE TO (c) Arteriosclerotic Heart Disease	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. He has had another Cor. Thrombosis several years ago.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 15, 1969 *to* June 15, 1969 *that I last saw the deceased alive on* Dec. Mons 19__, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm H Anderson, M.D.	Buhl, Idaho	6-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	June 18, 1969	Buhl Cemetery	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 24, 1969	Marva D. Marsh	George Farmer	E-480

FIRM NAME: Albertson-Dickard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

JUN 25 1969

Bureau of Vital Statistics

State File No. 2961
Local Reg. No. D-211
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
STAY (in this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 1023 "H" Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Veronica		BILL	June 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	December 8, 1893	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Eureka, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Ulrich	Peoria, Illinois	Veronica Riesser	Eureka, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	-	518-34-3006	E. E. Bill	Rupert, Idaho

2 4709

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute hemolytic anemia — 2 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-19-54, 19___, *to* 6-14, 1969, *that I last saw the deceased alive on* 6-14, 1969, *and that death occurred at* 3:50 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George E. Brown, MD	Twin Falls, Idaho	6-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	June 16, 1969	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 23, 1969	Marva D. Marsh	Charles H. Parsons	E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 2962
Local Reg. No. D-216
Reg. Dist. No. 460

Certificate of Death

RECEIVED
JUN 27 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 431
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 25 days 325
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 420
d. STREET ADDRESS (If rural, give location) Route 4

3. NAME OF DECEASED (Type or Print)
a. (First) BERLIN
b. (Middle) WALKER
c. (Last) GOFF

4. DATE OF DEATH (Month) (Day) (Year) June 16, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Mar15,1969
9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR Months 3 Days 1 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY agriculture
11. BIRTHPLACE (State or foreign country) Parsons, West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walker Goff — BIRTHPLACE West Virginia
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 518-60-8415J1
17. INFORMANT'S OWN SIGNATURE Neal Goff — ADDRESS Buhl

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease with congestive failure — INTERVAL BETWEEN ONSET AND DEATH 3 wks.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Aortic aneurysm — sev. years
DUE TO (c) Severe osteoarthritis — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Bladder neck structure — 3 wks
sev. weeks obstructive following Prostatectomy — sev. years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 10, 1969, *to* 6-16, 1969, *that I last saw the deceased alive on* 5-22, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Vern Henderson, M.D. 011
23b. ADDRESS Buhl, Ida
23c. DATE SIGNED 6-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE June 19, 1069
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. June 24, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER George Farmer
LICENSE NO. E-480

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2963
Local Reg. No. D-214
Reg. Dist. No. 460

RECEIVED JUN 27 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 969 2nd. Av. West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLYDE	LEE	BRIGGS	June 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married 3	Feb. 29, 1888	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Building	Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNK	UNK	UNK	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	0	503-05-7121A	*Benjamin L Briggs	Twin Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Perinephric abscess, right kidney	10 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Chronic pyelonephritis, bilateral	10 yrs. +
DUE TO (c)	Left renal calculi	unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Severe generalized arteriosclerosis	15 yrs.
	Paralytic ileus	5 days
	pulmonary emphysema, severe	15 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES XX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/28, 1968, *to* 6/17, 1969, *that I last saw the deceased alive on* 6/17, 19 69, *and that death occurred at* 7:30p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
489 James H. Gafford, M.D.	284 Martin Street Twin Falls, Idaho 83301	6/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 20, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 24, 1969	Marva D. Marsh	Jerry D. Holman	E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP. 07 2010

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2964
Local Reg. No. D-215
Reg. Dist. No. 460

RECEIVED JUN 27 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 420
d. STREET ADDRESS (If rural, give location): 1420 4th Av. East

3. NAME OF DECEASED (Type or Print)
a. (First): CORA
b. (Middle): B.
c. (Last): SUMMERS

4. DATE OF DEATH (Month) (Day) (Year): June 18, 1969

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 16, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Summers — BIRTHPLACE: UNK
14. MOTHER'S MAIDEN NAME: UNK — BIRTHPLACE: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY: 518-18-5712
17. INFORMANT'S OWN SIGNATURE: Eugene A Summers — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2d

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis, generalized — 10 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetes Mellitus senile type — 5 yrs.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* June, 1969, *that I last saw the deceased alive on* 18 June, 1969, *and that death occurred at* 10:55 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE 293 (Degree or title): Werner H Kramer MH
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 6-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 21, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: June 24, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Edgar J Robertson — LICENSE NO. E-507

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2965
Local Reg. No. D-213
Reg. Dist. No. 460

RECEIVED
JUN 27 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY TwinFalls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 421
d. STREET ADDRESS (If rural, give location) 1708 Poplar

3. NAME OF DECEASED (Type or Print)
a. (First) ISAAC
b. (Middle)
c. (Last) HANDLEY

4. DATE OF DEATH (Month) (Day) (Year) June 19, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH August 1, 1896
9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sheepman 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Tenn.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 548 03 4957-A
17. INFORMANT'S OWN SIGNATURE Ralph L. Wetherbee ADDRESS Castro, Valley Calif. 22302 CenterStreet

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5192

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Staph Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Lung disease — years
~~DUE TO~~ (c) Chronic Renal failure — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 15, 1969, *to* June 19, 1969, *that I last saw the deceased alive on* June 19, 1969, *and that death occurred at* 3:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE Russell W. Newcomb 881 (Degree or title) MD1
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 6.23.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 6.21.69
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. June 24, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Jerry D. Holman
LICENSE NO. E-516
FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2966
Local Reg. No. D-223
Reg. Dist. No. 460

RECEIVED JUL 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls (421)
b. CITY OR TOWN: Twin Falls (317)
c. LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Mem. Hospital (13)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl (420)
d. STREET ADDRESS (If rural, give location): 721 North Broadway

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	R.	WHITED	June 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married (3)	Dec. 12, 1885	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe Fitter (11)	Construction	Wright County, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Whited	No Record	Jane Riley Mrs. Vern Whited	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No (8)	519-01-5054	Mrs. Vern Whited (9)	Buhl, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days sev. yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis Fracture neck rt femur — 5 days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
XX (1)	Buhl, Idaho	Buhl, Twin Falls, Idaho (13) (420)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
June 14, 1969 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell after a dog bite. Pain in rt hip.

22. *I hereby certify that I attended the deceased from* 6-14, 1969, *to* 6-21, 1969, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Tom H. Anderson M.D. (011)	Buhl, Idaho	6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial (1)	6/25/69	Buhl	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 3, 1969	Marva D. Marsh	Robert T. Dickard	E-312

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 2967
Local Reg. No. D-212
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 JUN 27 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY IN this place) 3 yrs. 103
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sky View Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 421
d. STREET ADDRESS (If rural, give location) 383 Madison

3. NAME OF DECEASED (Type or Print) a. (First) ARETTA b. (Middle) c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year) June 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed 2	Sept. 16, 1877	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Payson, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Sabin	England	Mary Powell	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 3	518-56-8828	x C.C. Johnson	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis generalized 10yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4339

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from _____, 19 67, to June, 19 69, that I last saw the deceased alive on 27 June 19 69, and that death occurred at 6 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Werner H Kramer MD 293	Twin Falls Ida	6-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	6-25-69	Provo City Cemetery	Provo, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June 24, 1969	Marva D. Marsh	Dale L. Patterson	E-451

FIRM NAME Twin Falls Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 20 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2968
Local Reg. No. D 218
Reg. Dist. No. 46C

RECEIVED
Bureau of Vital Statistics
JUN 30 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN Twin Falls 83301
c. LENGTH OF STAY (at this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Hazeldell Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN Twin Falls, 83301 421
d. STREET ADDRESS (If rural, give location) 824 Park Ave

3. NAME OF DECEASED (Type or Print): a. (First) ETHEL b. (Middle) M. c. (Last) WILLIAMS

4. DATE OF DEATH (Month) (Day) (Year): June 24, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: December 21, 1908
9. AGE (In years last birthday): 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 1 HR.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 87
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Vinita, Oklahoma
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: George William Seigel — BIRTHPLACE: Monticello, Iowa
14. MOTHER'S MAIDEN NAME: Anna Jane Anderson — BIRTHPLACE: Kinnison, Okla IT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518 40 9069
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: 10806 Wooddale Tacoma, Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcioma of the Pancreas
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: April 16, 1969
19b. MAJOR FINDINGS OF OPERATION: Carcioma of Pancreas with Metastases to Mesentery and omentum and liver
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/31/69, 19___, to June 23, 19 69, that I last saw the deceased alive on June 23, 19 69 and that death occurred at 5:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): [signature] MD
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 6.24.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6.27.1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: June 27, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: [signature]
LICENSE NO.: E-516

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary TwinFalls, Idaho

MAR 30 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2969
Local Reg. No. D-219
Reg. Dist. No. 460

RECEIVED JUL 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 833 Shoshone St. No. Reed Apts.

3. NAME OF DECEASED (Type or Print): a. (First) EVELYN b. (Middle) BELLE c. (Last) AIKMAN

4. DATE OF DEATH (Month) (Day) (Year): June 26, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 20, 1895
9. AGE (In years last birthday): 74 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaking
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: E. N. Lindsay — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Hattie Lowell — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 568 46 6514
17. INFORMANT'S OWN SIGNATURE: Arline E. McKinney — ADDRESS: San Mateo, Calif.

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A.S.H.D. — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Embolism — 2 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/62, 19—, *to* 6/25, 1969, *that I last saw the deceased alive on* 6/25, 1969, *and that death occurred at* 5:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 578 — 23b. ADDRESS: 204 4th Ave. E. Twin Falls, Ida. — 23c. DATE SIGNED: 6/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Park
24d. LOCATION (City, town, or county) (State): Omaha, Nebraska

DATE REC'D BY LOCAL REG.: June 30, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Edgar J. Robertson
LICENSE NO.: E-507
FIRM NAME: White Mortuary — Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2970
Local Reg. No. D-224
Reg. Dist. No. 460

BIRTH NO.

JUL 10 1969

Bureau of Vital Sta. Stats.

1. PLACE OF DEATH 421 a. COUNTY Twin Falls	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO Falls b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 421
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143	d. STREET ADDRESS (If rural, give location) 246 4th Av. East

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) G.	c. (Last) MILLER	4. DATE OF DEATH (Month) (Day) (Year) June 26, 1969
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4	8. DATE OF BIRTH April 2, 1886	9. AGE (In years last birthday) 83 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Homemaking	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Edwin Gilbert	BIRTHPLACE Missouri	14. MOTHER'S MAIDEN NAME Elizabeth Samsel	BIRTHPLACE Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 2 (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 519-10-9584	17. INFORMANT'S OWN SIGNATURE RECORDS by Jerry D. Holman	ADDRESS Twin Falls, Idaho	

4319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral hemorrhage	2 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebrovascular arteriosclerosis	5 years+
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic heart disease	10 years+

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 April, 1969, *to* 26 June, 1969, *that I last saw the deceased alive on* 26 June, 1969, *and that death occurred at* 11:10P *m., from the causes and on the date stated above.*

23a. SIGNATURE 489 James H. Spaffard (Degree or title) M.D.	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 7/4/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 30, 1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho		
DATE REC'D BY LOCAL REG. July 7, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Edgar J. Robertson
LICENSE NO. E-507		

FIRM NAME WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2971
Local Reg. No. D-221
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: T.Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 421
d. STREET ADDRESS (If rural, give location): 138 Quincy Street

3. NAME OF DECEASED (Type or Print)
a. (First): SALVATORE
b. (Middle):
c. (Last): LONGOBARDO

4. DATE OF DEATH (Month) (Day) (Year): June 27, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 10, 1896

9. AGE (In years last birthday): 73
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Section Foreman 29

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Asri, Italy

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Tomazo Longobardo
BIRTHPLACE: Italy

14. MOTHER'S MAIDEN NAME: unknown
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.#1 3

16. SOCIAL SECURITY NO.: 712-07-7166

17. INFORMANT'S OWN SIGNATURE: Mrs. Salvatore Longobardo ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Coronary disease

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1963 to 6/27/, 1969, *that I last saw the deceased alive on* 6-27, 1969, *and that death occurred at* 12:40p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): M.D.

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 6-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/1/69

24c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: July 1, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: James C. Reynolds [signature]

LICENSE NO.: E-279

FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 8 1969

JUL 1 1 1969

SEP 1 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2972
Local Reg. No. D. 220
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY T.Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 621 Pierce Street

3. NAME OF DECEASED (Type or Print) a. (First) MAURINE b. (Middle) SPEER c. (Last) FISHER
4. DATE OF DEATH (Month) (Day) (Year) June 28, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 26, 1904
9. AGE (In years last birthday) 64
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hays, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME E.M. Speer BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Mae BIRTHPLACE Illinois
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 3 0
16. SOCIAL SECURITY NO. 518-30-8354
17. INFORMANT'S OWN SIGNATURE Howard R Fisher ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 1 hr.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease & L.B.B.B. — 6 mos
DUE TO (c) Arteriosclerotic Heart Disease & Hypertension — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myasthenia Gravis — 1 yr.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1953 – , 19 ___ , *to* 6/28/ , 19 69 , *that I last saw the deceased alive on* 6 28 69 , 19 ___ , *and that death occurred at* 10:05a. m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph W. Marshall 330 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 6/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/30/69
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. July 1, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
EMBALMER James C. Reynolds
LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2973
Local Reg. No. 24
Reg. Dist. No. 3/8

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Valley 430 JUN 17 1969 3/4
b. CITY OR TOWN (If outside corporate limits, write RURAL and give location) McCall
c. LENGTH OF STAY (In this place) 2 weeks
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Payette Lakes Nursing Home 324

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
d. STREET ADDRESS (If rural, give location) Box 616

3. NAME OF DECEASED (Type or Print) a. (First) LUCILLE b. (Middle) B. c. (Last) KELLEY
4. DATE OF DEATH (Month) (Day) (Year) June 10, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 30, 1900
9. AGE (In years last birthday) 69
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beauty Operator 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Big Horn, Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William L. Baker BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Minnie Enos BIRTHPLACE Texas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 2 0
16. SOCIAL SECURITY NO. 518-09-3647
17. INFORMANT'S OWN SIGNATURE Marie B. Spaulding ADDRESS Cascade, Idaho

18. CAUSE OF DEATH 4369
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH 3 WKS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) CASCADE (COUNTY) VALLEY (STATE) IDA
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MAR 56 *19__, to* JUNE *19 64, that I last saw the deceased alive on* JUNE 10, *19 64, and that death occurred at* 7P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 376 John F. Moon MD
23b. ADDRESS CASCADE, IDA
23c. DATE SIGNED 6/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 13, 1969
24c. NAME OF CEMETERY OR CREMATORY Margaret Cemetery
24d. LOCATION (City, town, or county) Cascade, (State) Idaho

DATE REC'D BY LOCAL REG. June-15-1969
REGISTRAR'S SIGNATURE Myrtle M. Gardner
25. EMBALMER Burton C. Walker
LICENSE NO. E-386
FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2974
Local Reg. No. 23
Reg. Dist. No. 310

BIRTH NO.

JUN 24 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: 430 Valley	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade	c. LENGTH OF STAY (In this place): DOA 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cascade Hospital 152	d. STREET ADDRESS (If rural, give location): 3230 North 32nd Street

3. NAME OF DECEASED (Type or Print) a. (First): ROBERT	b. (Middle): J.	c. (Last): NEAL	4. DATE OF DEATH (Month) (Day) (Year): June 15, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: Jan. 12, 1905	9. AGE (In years last birthday): 64 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer 21	10b. KIND OF BUSINESS OR INDUSTRY: State Highway Dept.	11. BIRTHPLACE (State or foreign country): Cape Girardeau, Mo	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Curtis J. Neal	BIRTHPLACE: Franklin Co., Ill.	14. MOTHER'S MAIDEN NAME: Rosena Muller	BIRTHPLACE: Switzerland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2	(If yes, give war or dates of service): -0	16. SOCIAL SECURITY NO.: 496-12-4228	17. INFORMANT'S OWN SIGNATURE: Hazel Neal	ADDRESS: 3220 N. 32nd St. Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Arteriosclerotic heart disease with congestive + heart failure and multiple arrhythmias

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 7+ yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 June, 1968, *to* 15 June, 1969, *that I last saw the deceased alive on* 10 June, 1969, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Hugh Attleby 014	(Degree or title): MO 1	23b. ADDRESS: 401 Idaho St Boise Ida	23c. DATE SIGNED: 19 June 69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: 6-18-69	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: June 21-1969	REGISTRAR'S SIGNATURE: Myrtle M Gardner	25. EMBALMER: Robert G. Ross	LICENSE NO.: E-497

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 2975
Local Reg. No. 35
Reg. Dist. No. 320

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUN 19 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Washington 440
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Midvale
c. LENGTH OF STAY: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Midvale 440
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Jacqueline
b. (Middle): Kay
c. (Last): Holmstrom

4. DATE OF DEATH (Month) June (Day) 4 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: August 4, 1968
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 10 Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---- 02
10b. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (State or foreign country): Elko, Nevada
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: David Holmstrom — BIRTHPLACE: Minneapolis, Minn.
14. MOTHER'S MAIDEN NAME: Lois Colson — BIRTHPLACE: Midvale, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 8
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: David Holmstrom — ADDRESS: Midvale, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suffocation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aspiration of food
DUE TO (c) into the trachea

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on* dead 6-4-69, 19__, *and that death occurred at* 1:30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 372 Rogue M.D.
23b. ADDRESS: Council, Idaho
23c. DATE SIGNED: 6-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Eastside Cemetery
24d. LOCATION (City, town, or county): Midvale (State): Idaho

DATE REC'D BY LOCAL REG.: 6-7-69
REGISTRAR'S SIGNATURE: R. Jane Thomason
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 20 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2976
Local Reg. No. 36
Reg. Dist. No. 320

Certificate of Death

RECEIVED
JUN 19 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 440
a. COUNTY: Washington 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place): 10 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 801 North 8th Street

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): B.
c. (Last): Hylton

4. DATE OF DEATH (Month) (Day) (Year): June 7, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 3, 1886
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Contractor 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Benjamin Hylton — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): -0
16. SOCIAL SECURITY NO.: 519-22-4507A
17. INFORMANT'S OWN SIGNATURE: Harold G Hylton — ADDRESS: New Plymouth, Idaho

18. CAUSE OF DEATH 4123
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive failure — 72h
DUE TO (c) Arteriosclerotic H.D. — 10y

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
conv. fx rt hip, chronic br syndrome

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/8, 1969 *to* 6/7, 1969 *that I last saw the deceased alive on* 6/6, 1969 *and that death occurred at* 8:48 *m., from the causes and on the date stated above.*

23a. SIGNATURE 186 (Degree or title): M.D.
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 6-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6-10-1969
24c. NAME OF CEMETERY OR CREMATORY: Park View
24d. LOCATION (City, town, or county) (State): New Plymouth Idaho

DATE REC'D BY LOCAL REG.: 6-8-69
REGISTRAR'S SIGNATURE: R. Dave Thomason
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 20 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 2977
Local Reg. No. 37
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 441 — JUN 19 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser — c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser 440
d. STREET ADDRESS (If rural, give location): 745 E. Lib.

3. NAME OF DECEASED (Type or Print): a. (First) PETE — b. (Middle) — c. (Last) SKOW

4. DATE OF DEATH: (Month) June (Day) 7 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 21, 1880

9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 07

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Denmark

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Peder Nelson Skow — BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: Kirsten Marie — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 985X

17. INFORMANT'S OWN SIGNATURE: Morgan Skow — ADDRESS: Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Death was due to a self-inflicted gunshot wound in the left upper thoracic region. Eye witness called the Sheriff immediately.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

Investigated by Sherrif & Justice of Peace

22. *I hereby certify that I attended the deceased from* ____, 19__ *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 588 Wash. Co. Justice of Peace

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: June 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: June 10, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Weiser, Idaho

DATE REC'D BY LOCAL REG.: June 7, 1969

REGISTRAR'S SIGNATURE: K. Dan Thomas

25. EMBALMER: Marshall S. Dickerson Jr. — LICENSE NO.: E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 1 1 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2978
Local Reg. No. 38
Reg. Dist. No. 320

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Washington 441 JUN 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (If this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital 153

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser 441
d. STREET ADDRESS (If rural, give location) 252 W. Liberty

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) OBED
c. (Last) MCCAMISH

4. DATE OF DEATH (Month) June (Day) 8 (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov.13,1889
9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Fayetteville, Arkansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John McCamish BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME Margaret Reed BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Hilda McCamish ADDRESS Weiser, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Heart Disease
DUE TO (c) Hypertension

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

402X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-19-, 1969, *to* 6-8-, 1969, *that I last saw the deceased alive on* 6-8-, 1969, *and that death occurred at* 1:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE M.D. McGrath MD 341 (Degree or title)
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED June 8,1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE June 11,1969
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. June 8, 1969
REGISTRAR'S SIGNATURE R. Dave Thomason
25. EMBALMER Marshall S. Dickerson Jr.
LICENSE NO. E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2979
Local Reg. No. 39
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington JUL 1 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (In this place) Bureau of Vital Statistics 086
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) Park Haven Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Sophia	Gilbertson	Daffer	6	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	widowed 2	7/21/1874	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 61	own home	Blair, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Gilbertson	Norway	Mattie Gran	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	0	4123	Olsen & Daffer	Weiser, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Senility

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-20-, 1964, *to* 6-22-, 1969, *that I last saw the deceased alive on* 6-22-, 1969, *and that death occurred at* 2:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Weiser, Idaho	6/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	6/25/69	Hillcrest Cemetery	Weiser Washington Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-22-69	K. Dee Thomason	K. Dee Thomason	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 2 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

R10T
6003
OVERLAND

Certificate of Death
STATE OF IDAHO

State File No. 2980
Local Reg. No. 486
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place) DOA 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location) 1318 River Street

3. NAME OF DECEASED (Type or Print) a. (First) Ira	b. (Middle)	c. (Last) Blankinship	4. DATE OF DEATH (Month) (Day) (Year) 6-29-69	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH 12-31-77	9. AGE (In years last birthday) 91 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Joplin, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bill Blankinship	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Emma Shira	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2	(If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 518-10-6902	17. INFORMANT'S OWN SIGNATURE Sabin L. Blankinship	ADDRESS 9302 W. Wright St Rt 3

4412

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Rupture, acute spontaneous abdominal aneurysm

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Chronic passive congestion

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Coronary arteriosclerosis	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 24, 1969, *to* _____, 19__, *that I last saw the deceased alive on* June 24, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 447 FK Root J MD 1 (Degree or title)	23b. ADDRESS Boise Idaho	23c. DATE SIGNED 7-14-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7-2-69	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. July 29 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Clyde J. Vassar	LICENSE NO. E-535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 4 1969
FEB 1 2 1970
DEC 2 8 1977
JUL 2 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Item 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2981
Local Reg. No. 454
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 — JUL 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 4 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 706 Brumback

Bureau of Vital Statistics 104

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEHI		HARDMAN	July 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Dec. 12, 1902	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter 21	Self Employed	Osmond, Lincoln, Wyoming	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Hardman	Utah	Agnes Hill	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	0	529-03-2795-A	X Leta Hardman	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Anticoagulant therapy

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/7, 1969, *to* July 1, 1969, *that I last saw the deceased alive on* 7/1, 1969, *and that death occurred at* 12 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
054 [illegible] MD	Boise	7/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-7-1969	Syringa Gardens	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer	Conway Grant	E-478

Federal Security Agency
United States Public Health Service

Form DH-630219 Helen Olson

FIRM NAME: Relyea Mortuary

DUTIES:

OCT 29 1973

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 23 2004

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 22 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Moody
2429 N. Cole Rd

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2982
Local Reg. No. 237
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
JUL 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
Bureau of Vital Statistics
c. LENGTH OF STAY (In this place): 3 years 103
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 392

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1124 N. 23 rd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
August		Heine	July 1 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed 2	Oct. 1 1881	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Doctor 14	Medical	Hooper, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
August Heine	Germany	Anna Lennemann	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 3	no 0	503-362-7585	Mrs. Frank Steinmeyer	Salem Ore

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

0399

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gram Neg Infection — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Urinary Tract Infection
DUE TO (c) Severe Deg Arthritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* 6/30, 1969, *that I last saw the deceased alive on* 6/30, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
368 R Bruce Moody MD	2429 N. Cole Rd	7/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 3 1969	St. John's sect. Morris Hill	Boise, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 7 1969	Myrtle Palmer	Daniel G. Gibson Gibson	400

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 2983
Local Reg. No. 80
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 ADA
JUL 8 1969
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
STAY (in this place) 24 DAYS
c. FULL NAME OF HOSPITAL OR INSTITUTION VA HOSPITAL, BOISE, IDA. 084 324
d. STREET ADDRESS (If rural, give location) 144 COLORADO AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY PAYETTE 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) FRUITLAND

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LAWRENCE	W.	WARDEN	JULY 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	WHITE	WIDOWED 2	OCTOBER 8, 1894	74	---	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER 04	FARMING	EVANS, COLORADO	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JAPHEJA WARDEN	MISSISSIPPI	SARAH DARE	MISSISSIPPI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI 4123	518-07-3660	Edmund Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 7 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I VA attended the deceased from JUNE 7, 1969, to JULY 1, 1969, and that death occurred at 6:05 a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis, M.D. 597 M.D. 1 ROBERT C. LEWIS, M.D.	VA CENTER, BOISE, IDAHO	7-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal Burial 3	7-5-1969	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 7, 1969	Myrtle Palmer	Keith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 2984
Local Reg. No. 84
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 JUL 11 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 500 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sandy Point at Lucky Peak 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 4500 State Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
RALPH	E.	CAPPER	July	2	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Dec. 27, 1946	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attendent 06	Service Station	Nyssa, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Percy P. Capper	Nebraska	Myrtle Osnes	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
No 2	543-56-6156	Geray P. Capper 417 Good Ave. Nyssa, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Asphyxiation by drowning. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. While wadeing, & swiming, steped into deep hole. Brief

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident 1	18	13	000	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 445P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 E.D. Pair	Coroner 4	3720 Meadow Drive, Boise.	7-8-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	July 7, '69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Myrtle Palmer	Robert G. Ross	E-497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 1 1969

FEB 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2985
Local Reg. No. 449
Reg. Dist. No. 37

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 JUL 14 1969
b. CITY OR TOWN Boise
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hosp 002

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN Boise
d. STREET ADDRESS 2717 Madison

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALVORD	E	HUBBARD	July 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 24, 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter 21	Painting	Springer, New Mexico	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alvord E. Hubbard	Mass.	Amelia Deacy	New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3		X Wilhelmina Hubbard	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH 2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema — 2 years.
DUE TO (c) Smoking

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

492X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10-13 1965, to 7-2, 1969, that I last saw the deceased alive on July 2 1969, and that death occurred at 2 3/4 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald McLeod 318 MD	Boise Idaho	7/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-7-1969	Syringa Gardens	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer	Eldon T. Pearson	E-512

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021 by Helen Olson

DUTIES:

JUL 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2986
Local Reg. No. 440
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
JUL 8 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2807 Taft Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2807 Taft Street

3. NAME OF DECEASED (Type or Print): a. (First) Frank; b. (Middle) Pierce; c. (Last) O'Neil

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: Nov. 19, 1891

9. AGE (In years last birthday): 77
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Associate Warden
10b. KIND OF BUSINESS OR INDUSTRY: State Penitentiary

11. BIRTHPLACE (State or foreign country): Phillipsburg, Mont.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alexander O'Neil
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Rhoda Austin
BIRTHPLACE: Grayson Co., Va.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 518-16-1400

17. INFORMANT'S OWN SIGNATURE: Jessie Myers by [signature]
ADDRESS: [illegible]

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1533

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma of colon c
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Metastases to lungs, liver & bone
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3½ yrs.

19a. DATE OF OPERATION: 6/28/66

19b. MAJOR FINDINGS OF OPERATION: Ca of ascending colon c regional lymph node metastases

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1965, *to* 7/2/, 1969, *that I last saw the deceased alive on* 6/11/, 1969, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.

23b. ADDRESS: 901 E. Bannock, Boise

23c. DATE SIGNED: 7/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-7-1969

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: July 8 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. E. Alden

LICENSE NO.: E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 8 - 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2987
Local Reg. No. 458
Reg. Dist. No. 370

RECEIVED Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
JUL 14 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 13 Yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 901 N. 7th

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Lukes Hospital 002

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ida	Margaret (Peggy)	Daniel	July 3 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Divorced 4	Aug. 24 1909	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tax Collector 08	State of Idaho	Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Stewart	Unknown	Mary Frakes	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 0	544-14-8845	Rita M. Meyer	Boise Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2001

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) LYMPHOSARCOMA — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1959 19__, *to* July 3, 1969, *that I last saw the deceased alive on* July 3, 1969, *and that death occurred at* 8:25 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm Rudisaile 071	MD	848 La Cassia, Rupa	7-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-7-69	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer by Helen Olson	Donald F Brown	E-408

FIRM NAME: Payette Chapel of the Roses

Federal Security Agency
United States Public Health Service
Form DH-630215

JUL 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2988
Local Reg. No. 81
Reg. Dist. No. 371

RECEIVED
Bureau of Vital Statistics
JUL 8 1969

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 011 ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
LENGTH OF STAY 20256 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDA.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 1000 NORTH LIBERTY ROAD

3. NAME OF DECEASED (Type or Print) 004
a. (First) JOHN
b. (Middle) WILLIAM
c. (Last) GOEKEN

4. DATE OF DEATH (Month) (Day) (Year) JULY 3 1969

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3

8. DATE OF BIRTH JUNE 9, 1904

9. AGE (In years last birthday) 65
IF UNDER 1 YEAR: Months ---- Days ----
IF UNDER 24 HRS.: Hours ---- Min. ----

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HEAVY EQUIPMENT OPERATOR 11

10b. KIND OF BUSINESS OR INDUSTRY SAME

11. BIRTHPLACE (State or foreign country) EDMOND, KANSAS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOHN P. GOEKEN
BIRTHPLACE PENNSYLVANIA

14. MOTHER'S MAIDEN NAME NORA MC CORMICK
BIRTHPLACE IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES
(If yes, give war or dates of service) WWII & KOREAN

16. SOCIAL SECURITY NO. 519-16-6648

17. INFORMANT'S SIGNATURE James R. Worthy
ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 9 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral metastasis — 3 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. ~~I last saw deceased alive on [illegible] 19[illegible], and that death occurred at [illegible] m.~~ VA attended the deceased from MAY 8, 1969, to JULY 3, 1969, ~~that I last saw the deceased alive on [illegible] 19[illegible]~~, and that death occurred at 2:58 p. m., from the causes and on the date stated above.

23a. SIGNATURE 597 O. G. RIML, M.D. (Degree or title)

23b. ADDRESS VA CENTER, BOISE, IDAHO

23c. DATE SIGNED 7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-7-1969

24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. July 8 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER A. E. Alden
LICENSE NO. E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 8 - 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2989
Local Reg. No. 777
Reg. Dist. No. 370

BIRTH NO. RECEIVED JUL 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 5 days 305

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Elmore 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
d. STREET ADDRESS (If rural, give location) 935 E. 17th North

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsas Hospital 003

3. NAME OF DECEASED (Type or Print) a. (First) Effie b. (Middle) E. c. (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Jan, 15, 1919
9. AGE (In years last birthday) 50
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Airforce Nurse 05
10b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.
11. BIRTHPLACE (State or foreign country) McCall, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John S. Johnson
BIRTHPLACE Finland
14. MOTHER'S MAIDEN NAME Hannah Sirnoen
BIRTHPLACE Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes / Active Duty 8
16. SOCIAL SECURITY NO. 565-38-8554
17. INFORMANT'S OWN SIGNATURE Family records
By Genevieve Caswell Boise Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ventricular fibrillation
DUE TO (c) Massive myocardial infarction

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28, 1969, to July 3, 1969, that I last saw the deceased alive on July 3, 1969, and that death occurred at 9:20 A. m., from the causes and on the date stated above.

23a. SIGNATURE 005 Howard E. Allen (Degree or title) /
23b. ADDRESS 220 N. 1st St.
23c. DATE SIGNED 7/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial /
24b. DATE July 10, 1969
24c. NAME OF CEMETERY OR CREMATORY Finnish Cemetery
24d. LOCATION (City, town, or county) (State) Lake Fork, Idaho

DATE REC'D BY LOCAL REG. July 10, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Darrell W. Summers
LICENSE NO. E-509
FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 10 1969

SEP 11 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

State File No. 2990
Local Reg. No. 461
Reg. Dist. No. 370

BIRTH NO. -

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 yrs, 3Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1515 No. Mitchell

3. NAME OF DECEASED (Type or Print): a. (First) HATTIE b. (Middle) AMANDA c. (Last) KELLEY

4. DATE OF DEATH (Month) (Day) (Year): July 3, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 21, 1888

9. AGE (In years last birthday): 81
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: George Guiver
BIRTHPLACE: Essex, England

14. MOTHER'S MAIDEN NAME: Amanda Druce
BIRTHPLACE: Salt Lake City, Uta h

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): 8

16. SOCIAL SECURITY NO.: 518 26 8415A

17. INFORMANT'S OWN SIGNATURE: Russell V. Kelyea
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Arteriosclerotic Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Feb 1967, to July 3, 1969, that I last saw the deceased alive on July 2, 1969, and that death occurred at 4 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): C. C. Stinson MD

23b. ADDRESS: Boise Ida

23c. DATE SIGNED: 7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 7, 1969

24c. NAME OF CEMETERY OR CREMATORY: Carey Cemetery

24d. LOCATION (City, town, or county) (State): Carey, Idaho

DATE REC'D BY LOCAL REG.: 7-14-69

REGISTRAR'S SIGNATURE: Myrtle Pelmer
By Helen Olson

25. EMBALMER: Eldon T. Pearson

LICENSE NO.: E512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-6302

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2991
Local Reg. No. 442
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 4000 Greenbriar Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Frances	Suzanne	Bieber	July 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	May 28, 1936	33		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Seattle, Wn.	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Francis Minch	Odessa, Wn.	Maude Hughes	Thornton, Wn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2 0	518-42-7423	Richard N Bieber	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 174X Caranoma of Breast — INTERVAL BETWEEN ONSET AND DEATH 4yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 66 *to* July 4, 19 69, *that I last saw the deceased alive on* July 4, 19 69, *and that death occurred at* 6:32 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
577 Carol Cawdell M.D.	110 North Latah, Boise	7-5-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation 2	July 5, 1969	Mtn. View	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 8 1969	Myrtle Palmer	A. E. Alden	299

FIRM NAME: Alden-Waggoner

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 23 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED Certificate of Death
STATE OF IDAHO

State File No. 2992
Local Reg. No. 443
Reg. Dist. No. 370

BIRTH NO.

JUL 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3220 N. 36th St.

3. NAME OF DECEASED (Type or Print) a. (First) Russell 003 b. (Middle) Howard c. (Last) Foley
4. DATE OF DEATH (Month) (Day) (Year) July 4, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 18, 1910
9. AGE (In years last birthday) 58
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY auto industry
11. BIRTHPLACE (State or foreign country) Norton, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Foley BIRTHPLACE
14. MOTHER'S MAIDEN NAME Bertha Ellen Greer BIRTHPLACE Norton, Kansas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 3 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 518-09-2961
17. INFORMANT'S OWN SIGNATURE X Lorraine V. Foley ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Sclerosis & Cardiac Standstill. — INTERVAL BETWEEN ONSET AND DEATH about 3 mo
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) old myocardial infarction — This P.M.
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from D.O.A. St. Alphonsus, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6 P m., from the causes and on the date stated above.

23a. SIGNATURE E. R. Jones (Degree or title) M.D.
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/8/1969
24c. NAME OF CEMETERY OR CREMATORY Norton, Kansas
24d. LOCATION (City, town, or county) (State) Norton, Norton Co., Kansas

DATE REC'D BY LOCAL REG. July 9, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Paul Waggoner
LICENSE NO. E- 422
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2993
Local Reg. No. 438
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ada 011 JUL 8 1969

b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics) Boise

c. LENGTH OF STAY (In this place) 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convelesent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

d. STREET ADDRESS (If rural, give location) 543 Main Street

3. NAME OF DECEASED (Type or Print) a. (First) Clara b. (Middle) Lois c. (Last) Parks

4. DATE OF DEATH (Month) 7 (Day) 4 (Year) 69

5. SEX female

6. COLOR OR RACE caue.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH 4/2/1877

9. AGE (In years last birthday) 92 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Tracy, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Philander Benscoter BIRTHPLACE

14. MOTHER'S MAIDEN NAME Maira Voight BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0 (If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Patricia J. Barup ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

884X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	3-4 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Broken hip	6 mos
DUE TO (c)	Fall	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized arterio sclerosis	3 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE XX (Specify) 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Boise Convalescent Center 13

21c. (CITY, TOWN, OR TOWNSHIP) Boise 13 (COUNTY) Ada 011 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 3, 1969 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Fell getting out of bed

22. *I hereby certify that I attended the deceased from* aug, 1968, *to* death, 19____, *that I last saw the deceased alive on* June 28, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 046 C. R. Buchler MD (Degree or title) 1

23b. ADDRESS Boise, Idaho

23c. DATE SIGNED July 7, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1

24b. DATE July 8 1969

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. July 7 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Daniel G. Gibson Daniel G. Gibson LICENSE NO. 400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 2994
Local Reg. No. 464
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

JUL 15 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 12th Avenue Road

3. NAME OF DECEASED (Type or Print)
a. (First): Goldia
b. (Middle): Carrie
c. (Last): Voigt

4. DATE OF DEATH (Month) (Day) (Year): July 4, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 30, 1902
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home making 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Kamas, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles J. Peterson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Mary C. Smith — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 529-01-3937
17. INFORMANT'S OWN SIGNATURE: X Carl A Voigt — ADDRESS: Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2381

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 19__, *to* 69, 19__, *that I last saw the deceased alive on* July 4, 1969, *and that death occurred at* 10:20A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 583 [signature] 4
23b. ADDRESS
23c. DATE SIGNED: 7-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: 7-14-69
REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson
25. EMBALMER: Larry S. Krouch
LICENSE NO.: E-447

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 2995
Local Reg. No. 453
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011 — JUL 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION ST ALPHONSUS HOSPITAL 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO — b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 1101 No. 18th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RAY	W	CARTER	JULY 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED 3	FEB 10, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contracting, Plastering //	Contractor	PROVO, UTAH	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Enos Carter	Utah	Unita Whipple	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No. 2	---0---	519 09 6639 A	Sheldon R Carter	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 18 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4 July, 1969 *to* 5 July, 1969 *that I last saw the deceased alive on* 5 July, 1969 *and that death occurred at* 1:34a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
505 Lyle Stones, M.D.	220 N. 1st St., Boise, Idaho	11 July, '69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-8-1969	Cloverdale Cemetery	Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer by Helen Olson	Eldon T. Pearson	E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 16 1976

JUN 15 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 11 1969 Bureau of Vital Statistics

State File No. 2996
Local Reg. No. 82
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDA 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) OLYMPIA HOTEL

3. NAME OF DECEASED (Type or Print) a. (First) WARREN b. (Middle) J. c. (Last) GROBERG

4. DATE OF DEATH (Month) JULY (Day) 5, (Year) 1969

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED 4

8. DATE OF BIRTH JUNE 24, 1916

9. AGE (In years last birthday) 53
IF UNDER 1 YR. Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR AND DRY CLEANER 21

10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING

11. BIRTHPLACE (State or foreign country) CLAY CITY, KANSAS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME GEORGE GROBERG
BIRTHPLACE KANSAS

14. MOTHER'S MAIDEN NAME FRANCES PRINTZ
BIRTHPLACE KANSAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1
(If yes, give war or dates of service) WWII 4

16. SOCIAL SECURITY NO. 512-10-8708

17. INFORMANT'S OWN SIGNATURE Mrs. Mary Bentley
ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4389

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Edema due to unknown cause — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from JULY 5, 1969, to JULY 5, 19 69 XXXX

OCT 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2997
Local Reg. No. 445
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Ada 011 JUL 10 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Washington 48 b. COUNTY Snohomish
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau of Vital Statistics c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 555 Arlington
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location) Rt. 4, Box 71

3. NAME OF DECEASED (Type or Print) a. (First) Wayne	b. (Middle) A.	c. (Last) Peterson	4. DATE OF DEATH (Month) July	(Day) 5,	(Year) 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH Oct. 31, 1922	9. AGE (In years last birthday) 47	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator 11	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Washington	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Arthur Peterson	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Edith Bachman	BIRTHPLACE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1	(If yes, give war or dates of service) W.W. II 4	16. SOCIAL SECURITY NO. 536-26-2647	17. INFORMANT'S OWN SIGNATURE x Velma Peterson	ADDRESS Rt.4 Box 71 Arlington, Wash.	

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Thrombosis.	Brief
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Complained of severe pains in Chest. day, & evening before.	I day

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, that I last saw the deceased alive on _____ 19____, and that death occurred at* 215 AM *from the causes and on the date stated above.*

23a. SIGNATURE 583 D. Paris	(Degree or title) Coroner 4	23b. ADDRESS 3720 Meadow Drive, Boise.	23c. DATE SIGNED 7-8-69.
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE July 6, 1969	24c. NAME OF CEMETERY OR CREMATORY Arlington	24d. LOCATION (City, town, or county) (State) Arlington, Washington
DATE REC'D BY LOCAL REG. July 10, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Powell W. Hemsay	LICENSE NO. E-509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 10 1969

JUL 11 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2998
Local Reg. No. 451
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 808 N. Curtis

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Amanda	Ellen	Wakeman	July 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced 4	March 21, 1876	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Boise, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Silas S. Gray	Unk	Frances	Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE
No 2	0	519-16-9312	J. Quentin Wakeman 10840 Lindbrook Dr. Apt 2 Los Angeles 90024

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Osteresclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) None
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
No		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
No m.		

22. *I hereby certify that I attended the deceased from* 1967, 19__, to 1968, 19__, *that I last saw the deceased alive on* Feb, 1968, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
523 Keith A Taylor MD	119 E Idaho	7/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/8/1969	Star Cemetery	Star, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer by Helen Olson	Earl Waggoner	E-422

Federal Security Agency
United States Public Health Service FORM DH-6302

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2999
Local Reg. No. 459
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY 011 Ada — JUL 1 5 1969 — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor 292

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho — b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1226 Leadville Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	A.	BATES	July	6	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Dec. 25, 1888	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04		Coffeyville, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hugh C. Bates	Illinois	Lou Blackwell	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	519-01-8286	Mabel V. Bates	1226 Leadville Ave. Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1621 Adenoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5-12-69 *, 19____, to* 7-6-69 *, 19____, that I last saw the deceased alive on* 7-6-69 *, 19____, and that death occurred at* 12:15p *, from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
654 Walter A. Hall	M.D.	425 W. Bannock	7/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 9, '69	Terace Lawn	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer by Helen Olson	Gary A. Cowger	E-526

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME SUMMERS FUNERAL HOME

JUL 3 0 1974

FEB 2 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 3000
Local Reg. No. 473
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH — a. COUNTY: 011 Ada — JUL 25 1969 — 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 10 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescant Center 332

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE: Idaho — b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1818½ Idaho

3. NAME OF DECEASED (Type or Print): a. (First) EDITH — b. (Middle) ELLEN — c. (Last) BAYER
4. DATE OF DEATH (Month) (Day) (Year): July 6, 1969
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 31, 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Greene, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: John B. Shank — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Sadie Zook — BIRTHPLACE: Iowa
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No. 2 ----------
16. SOCIAL SECURITY NO.: 518-16-1265-T
17. INFORMANT'S OWN SIGNATURE: Harold L. Bayer — ADDRESS: Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral Vascular Accident
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Arteriosclerosis
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MARCH, 1962, *to* JULY, 1969, *that I last saw the deceased alive on* JULY 5, 1969, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 368 Bruce Moody MD
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-9-1969
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: July 22, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson
LICENSE NO.: E-512
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3001
Local Reg. No. 460
Reg. Dist. No. 370

BIRTH NO. RECEIVED

1. PLACE OF DEATH
a. COUNTY ADA 011 JUL 15 1969 319
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) 19 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST LUKE'S HOSPITAL 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO 13
b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 1705 HELEN

3. NAME OF DECEASED (Type or Print) a. (First) SADIE b. (Middle) INEZ c. (Last) HILTIBIDDLE

4. DATE OF DEATH (Month) (Day) (Year) July 6, 1969

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Aug 16, 1887
9. AGE (In years last birthday) 81 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Territory, Indian Oklahoma
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME George Spear Breedlove BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Lucinda Hankens BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. 2 (If yes, give war or dates of service) ----0------
16. SOCIAL SECURITY NO. 518-12-2640
17. INFORMANT'S OWN SIGNATURE X Maxine Runge ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 14 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 28, 1968, *to* July 6, 1969, *that I last saw the deceased alive on* July 5, 1969, *and that death occurred at* 4:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE 333 [signature] (Degree or title) 1
23b. ADDRESS 808 La Cassia Boise
23c. DATE SIGNED 7-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 7-9-1969
24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens
24d. LOCATION (City, town, or county) Boise Ada (State) Idaho

DATE REC'D BY LOCAL REG. 7-14-69
REGISTRAR'S SIGNATURE Myrtle Palmer by Helen Olson
25. EMBALMER Eldon T. Pearson
LICENSE NO. E512

Federal Security Agency
United States Public Health Service FORM DH-63021
FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 19 1969
DEC 1 1969
SEP 9 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED JUL 17 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3002
Local Reg. No. 467
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 17 years 117
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1117 S. Orchard St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1117 S. Orchard St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RALPH	JOHN	KIELY	July 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	July 11, 1896	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Major 05	U. S. Army	St. Louis, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Kiely	Ireland	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Mexican WWI WWII	322-14-6832	Lucille B Kiely	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gun Shot Thru Head. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Illness, Despondant. Marital Troubles. — weeks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide 2		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 Coroner	3720 Meadow Drive. Boise.	7-11-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/10/69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-17-69	Myrtle Palmer by Helen Olson	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 17 1969
AUG 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Lyle Stones
220 N 1

Certificate of Death
STATE OF IDAHO

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

State File No. 3003
Local Reg. No. 465
Reg. Dist. No. 370
BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 001 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE South Dakota b. COUNTY Gregory 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 42 Fairfax,
d. STREET ADDRESS (If rural, give location) General

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) - c. (Last) Pratt
4. DATE OF DEATH (Month) (Day) (Year) July 6 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 21 1897
9. AGE (In years last birthday) 71 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 29
10b. KIND OF BUSINESS OR INDUSTRY retired
11. BIRTHPLACE (State or foreign country) Vermillion S. Dakota
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Pratt BIRTHPLACE South Dakota
14. MOTHER'S MAIDEN NAME Elizabeth Sparks BIRTHPLACE Scotland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 504-32-3191
17. INFORMANT'S OWN SIGNATURE Robert James Pratt ADDRESS Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4339

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Occlusion of right middle cerebral artery — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cerebrovascular disease unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease — several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 July, 1969, *to* 6 July, 1969, *that I last saw the deceased alive on* 5 July, 1969, *and that death occurred at* 3:50 a m., *from the causes and on the date stated above.*

23a. SIGNATURE 505 Lyle Stones (Degree or title) Lyle Stones, M.D.
23b. ADDRESS 220 N. 1st St., Boise, Idaho
23c. DATE SIGNED 7-7-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE July 7 1969
24c. NAME OF CEMETERY OR CREMATORY Bluff View
24d. LOCATION (City, town, or county) (State) Vermillion S. Dakota
DATE REC'D BY LOCAL REG. 7-16-69
REGISTRAR'S SIGNATURE Myrtle Palmer by Helen Olson
25. EMBALMER Daniel G. Gibson
LICENSE NO. 400
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
FORM PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 16 1969

JUL 6 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3004
Local Reg. No. 452
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 15 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1020 E. Bannock

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Maria	Dominga	Arregui	7	7	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	caue.	widow 2	3/10/1882	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Guizaburuaga, Spain	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Angel Goicoechea	Spain	Juana Arostegui	Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
O	O		+ Carmen Solosabal	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4121

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Hypertensive Cardiovascular Renal

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. Diabetis Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-7, 1969, *to* _____, 19____, *that I last saw the deceased alive on* 7-7, 1969, *and that death occurred at* 7:35 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. C. Gibson 361	MD	Boise Ida	7-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 10 1969	St. John's section Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer by Helen Dean	Daniel G. Gibson	400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM PH-63021

JUL 17 1969

JUL 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Cert. Copies

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 10 1969 Bureau of Vital Statistics

State File No. 3005
Local Reg. No. 83
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE — c. LENGTH OF STAY (In this place): 10 DAYS 310	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDA 004	d. STREET ADDRESS (If rural, give location): 2700 ONA STREET

3. NAME OF DECEASED (Type or Print)	a. (First): CHARLES	b. (Middle): EUGENE	c. (Last): SULLIVAN	4. DATE OF DEATH (Month) (Day) (Year): JULY 7, 1969
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3	8. DATE OF BIRTH: JULY 29, 1928	9. AGE (In years last birthday): 40 — IF UNDER 1 YR. Months — Days — IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COMMUNICATIONS OFFICER 05	10b. KIND OF BUSINESS OR INDUSTRY: U.S. AIR FORCE	11. BIRTHPLACE (State or foreign country): MOBILE, ALABAMA	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: MIKE A. SULLIVAN	BIRTHPLACE: ALABAMA	14. MOTHER'S MAIDEN NAME: ANNIE M. GARRETT	BIRTHPLACE: FLORIDA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES 1	(If yes, give war or dates of service): VIET NAM 7	16. SOCIAL SECURITY NO.: 424-30-8451	17. INFORMANT'S OWN SIGNATURE: James D. Bentley	ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION 5770

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pancreatitis.	3 weeks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Tuberculosis, pulmonary, apparently inactive.	3 years.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from JUNE 27, 1969, to JULY 7, 1969, and that death occurred at 4:02p m., from the causes and on the date stated above.

23a. SIGNATURE: FRED B. HINE, M.D. 597 (Degree or title) Fred B. Hine, MD	23b. ADDRESS: VA CENTER, BOISE, IDAHO	23c. DATE SIGNED: 7-8-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: July 10 1969	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: July 10 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Daniel G. Gibson, Gibson Funeral Home	LICENSE NO.: 400

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 10 1969

AUG 29 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3006
Local Reg. No. 447
Reg. Dist. No. 370

RECEIVED JUL 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 01 — 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescant Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rt. # 4
d. STREET ADDRESS (If rural, give location) Boise, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELSIE	F.	KING	July 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	~~Married~~ Widowed 2	July 8, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Davis City, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Hinkle	Unknown	Inez Shepherd	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	519-66-4559	X Mable Anne Borchardt	7013 Northview

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Congestive heart failure	2 yr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Myocardial infarction	10 yr
DUE TO (c)	Arteriosclerotic heart disease	20 yr
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4 May, 1960, *to* 8 July, 1969, *that I last saw the deceased alive on* 26 June, 1969, *and that death occurred at* 10:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. E. Wagner M.D.	Boise Idaho	10 July 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7-11-69	Tulsa Okla. Cemetery	Tulsa, Okla.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Myrtle Palmer	C. J. Vassar	E-535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Parkinson 207 N 3

Certificate of Death

STATE OF IDAHO

State File No. 3007
Local Reg. No. 455
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1412 North 16th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Helena	Martin	7	8	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	caue.	widowed 2	Nov 18, 1877	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Forest Grove, Oregon	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Paul Thomas	Luxemburg Germany	Katherine Graveldinger	Luxemburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	0		x Mary J. Martin	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

404X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Vasc. Renal Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Broke hip 3 mo. ago

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Senile Dementia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1958, *to* July, 1969, *that I last saw the deceased alive on* 9, *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE 407 Parkinson M.D. (Degree or title)

23b. ADDRESS 620 Hays St., Boise, Idaho

23c. DATE SIGNED 7-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 12, 1969

24c. NAME OF CEMETERY OR CREMATORY St. John's Section Morris Hill

24d. LOCATION (City, town, or county) (State) Boise Idaho

DATE REC'D BY LOCAL REG. 7-14-69

REGISTRAR'S SIGNATURE Myrtle Palmer by Helen Olson

25. EMBALMER Daniel G. Gibson

LICENSE NO. E 400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3008
Local Reg. No. 448
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 01 4/2
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 12 hours
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 6728 Fairview Ave.

3. NAME OF DECEASED (Type or Print) a. (First) RUEL b. (Middle) S. c. (Last) MYERS
4. DATE OF DEATH (Month) (Day) (Year) July 8, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 63
8. DATE OF BIRTH Oct. 31, 1888
9. AGE (In years last birthday) 80
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service 05
10b. KIND OF BUSINESS OR INDUSTRY Mnt. Home Air Base
11. BIRTHPLACE (State or foreign country) Lake City, Calif.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Myers BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Elizabeth M. Mott BIRTHPLACE Nevada
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 2
16. SOCIAL SECURITY NO. 519-03-1592
17. INFORMANT'S OWN SIGNATURE X Irene E Myers ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary emphysema & fibrosis — 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure — 3 yrs
Bronchitis — 1 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9 Sept 63 *to* 7 July 69 *, that I last saw the deceased alive on* 7 July 69 *, and that death occurred at* 3:00 p *m., from the causes and on the date stated above.*

23a. SIGNATURE 370 Charles E Mayo (Degree or title) M.D.
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 10 July 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/11/69
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. July 10, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER G. W. Waters
LICENSE NO. E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 1 1963

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 11 1969 Bureau of Vital Statistics

State File No. 3009
Local Reg. No. 85
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: ADA 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: OREGON 38 b. COUNTY: HARNEY 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE — LENGTH OF STAY (In this place): 15 DAYS 315	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BURNS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADM HOSPITAL, BOISE, IDAHO 004	d. STREET ADDRESS (If rural, give location): 1022 WEST MONROE STREET

3. NAME OF DECEASED (Type or Print) a. (First): DAVID	b. (Middle): (NONE)	c. (Last): UFFELMAN	4. DATE OF DEATH (Month) (Day) (Year): JULY 8, 1969	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3	8. DATE OF BIRTH: NOVEMBER 3, 1905	9. AGE (In years last birthday): 63 — IF UNDER 1 YR. Months: -- Days: -- — IF UNDER 24 HRS. Hours: -- Min.: --
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER 06	10b. KIND OF BUSINESS OR INDUSTRY: FARMING	11. BIRTHPLACE (State or foreign country): KANSAS CITY, KANSAS	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: JACOB UFFELMAN	BIRTHPLACE: GERMANY	14. MOTHER'S MAIDEN NAME: KATIE PROPP	BIRTHPLACE: GERMANY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES 1 — (If yes, give war or dates of service): WWII 4	16. SOCIAL SECURITY NO.: 518-12-19-34	17. INFORMANT'S OWN SIGNATURE: Ramona Bentley	ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO	

5719

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pulmonary embolism	few minutes
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Thrombophlebitis	4-6 weeks
DUE TO (c)	Cirrhosis of the liver	1 year
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. ~~[illegible]~~ attended the deceased from JUNE 23, 1969, to JULY 8, 1969 ~~[illegible]~~ ~~[illegible]~~, and that death occurred at 3:10 a.m., from the causes and on the date stated above.

23a. SIGNATURE: O.G. RIML, M.D. 597 (Degree or title)	23b. ADDRESS: VA CENTER, BOISE, IDAHO	23c. DATE SIGNED: 7-8-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 7-9-69	24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Burns, Oregon		
DATE REC'D BY LOCAL REG.: July 10, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Gary A. Cowger — LICENSE NO.: E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3010
Local Reg. No. 456
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 14 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 6 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 410 E. Jefferson

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Myrlin	V.	Bates	July 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	June 9, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Auto Mechanic 39	Mechanic	Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alexander Bates	Pennsylvania	Evelyn Burch	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. I 3	518-38-0438	Idelia J. Bates	410 E. Jefferson Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4360

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebrovascular Accident	1 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertension	20 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-29-65, 19__, *to* 7-9-69, 19__, *that I last saw the deceased alive on* 7-9-69, 19__, *and that death occurred at* 12:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
654 Walter M. Klein M.D.	425 W Bannock	7/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	July 14, 1969	Terrace Lawn	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer by Helen Olson	Robert G. Lee	E-497

Federal Security Agency
United States Public Health Service FORM PH-63021

FIRM NAME: Summers Funeral Home

-3-

JUL 14 1969
JUL 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 4 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3011
Local Reg. No. 474
Reg. Dist. No. 370

BIRTH NO.

JUL 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011 210	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — c. LENGTH OF STAY (In this place): 10 Months	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center. 332	d. STREET ADDRESS (If rural, give location): 1620 Bannock

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)	
RAYMOND	CARY	HAVIRD	July 9, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Spec): Married 3	8. DATE OF BIRTH: June 24, 1891	9. AGE (In years last birthday): 77 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Furnace Business 22	10b. KIND OF BUSINESS OR INDUSTRY: Furnaces	11. BIRTHPLACE (State or foreign country): Idaho City, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Cary Havird	BIRTHPLACE	14. MOTHER'S MAIDEN NAME: Helen Dodge	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. 2 (If yes, give war or dates of service): ------0--	16. SOCIAL SECURITY NO.: 518-09-7434-A	17. INFORMANT'S OWN SIGNATURE: X Edward C. Havird	ADDRESS: Idaho	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive Heart Failure

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arterio Sclerotic Heart Disease

DUE TO (c): Coronary atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.: Cerebral Vascular Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION: NONE	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1968, *to* July 9, 1969, *that I last saw the deceased alive on* July 8-69 *and that death occurred at* 6:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: John E. Cuppard 094 (Degree or title) M.D.	23b. ADDRESS: 311 - Idaho St	23c. DATE SIGNED: 7/14/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 7-14-1969	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery	24d. LOCATION (City, town, or county): Boise Ada (State) Idaho
DATE REC'D BY LOCAL REG.: July 22, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Eldon T. Pearson	LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 2 9 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 25 1969 Bureau of Vital Statistics

State File No. 3012
Local Reg. No. 475
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 300 South Straughn Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MAUDE	E.	OSTRANDER	July 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	Aug. 11, 1888	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	at home	Pocatello, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Rouse	England	Caroline Paver	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2 0--	571-72-4446	Helen D. McAuley	190 Chase Pocatello, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 mo

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease — 15 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Status post operative carcinoma of breast with metastases to axillary node — 4 yrs

4123

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29 December, 1966, to 10 July, 1969, that I last saw the deceased alive on 10 July, 1969, and that death occurred at 7:40 PM from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clayton C. Morgan	M.D.	Boise Idaho	17 July 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-12-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 23, 1969	Myrtle Palmer	Gary D. Cowger	E-526

FIRM NAME SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 3 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended August 28, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3013
Local Reg. No. 84
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Ada 010	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise (Garden City) c. LENGTH OF STAY (In this place): 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise (Garden City)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 204 W. 38th 000	d. STREET ADDRESS (If rural, give location): 204 W. 38th

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Roy	Melvin	Canfield		July	11,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cauc.	never married 1	Dec. 10, 1900	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Draftsman 21	Bur. of Pub. Roads	Traverse City, Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William E. Canfield	Michigan	Mary Ann Desmond	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	519-18-3355	Susan K. Johnson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

955X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gunshot thru Heart — Interval between onset and death: Brief

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Illness — Weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Suicide 2	Home 01	Garden City 13	Ada 010	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
			m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 6:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. D. Paris, Coroner 583 4	3720 Meadow Drive, Boise	7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	July 16,1969	Kooskia Cemetery	Kooskia, Idaho, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 14,1969	Myrtle Palmer	Daniel G. Gibson	400

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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8-28-69

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED

AUG 28 1969

Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss. Certificate No. 69-3013

County of ..... Date Filed .....

The undersigned does solemnly swear that certain facts on this certificate of Death (Birth or Death)

for Roy Canfield (Name on Original Certificate) who died (Was Born or Died) on July 11, 1969 (Date of Event)

in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	12/10/69	Dec. 10, 1900

Subscribed and sworn to before me this ..... day of ....., 19.....

Notary Public, residing at .....

My commission expires .....

(Seal)

X Signed Erle B. Byram

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

.....

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.

County of Ada

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 28th day of August, 1969

Ruby Hambelton

Notary Public, residing at Boise

My commission expires January 10, 1970

(Seal)

X Signed [signature]

(Signature of Any Credible Person)

.....

(Street Address, City, State)

FORM DH 60-155

8-12-69

RECEIVED

AUG 2 8 1969

Bureau of Vital Statistics

Roy Canfield died July 11, 1969

Boise, Idaho

Date of Birth 12/10/69 Dec. 10, 1900

STATE OF IDAHO * BUREAU OF VITAL STATISTICS * NAME VERIFICATION

Certificate of Death

RECEIVED JUL 15 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3013
Local Reg. No. 84
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise (Garden City)
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 204 W. 38th

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise (Garden City)
d. STREET ADDRESS (If rural, give location): 204 W. 38th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Roy	Melvin	Canfield	July	11	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caue.	never married	12/10/69	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
draftsman	Bu. of Pu. Roads	Traverse City, Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William E. Canfield	Michigan	Mary Ann Desmond	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-18-3355	X Susan K. Johnson	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gun Shot thru Heart. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cronic Illness — Weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Suicide	Home	Garden City	Ada	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 630A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. D. Paris	Coroner	3720 Meadow Drive, Boise,	7-14-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	7/16/69	Keoskia Cemetery	Keoskia	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 14 1969	Myrtle Palmer by Helen Dean	Daniel G. Gibson	400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 28 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3014
Local Reg. No. 82
Reg. Dist. No. 391

BIRTH NO.

RECEIVED JUL 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011 — 313
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (in this place): 13 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDA — 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO — b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 2300 PALOUSE

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEE	ROY	ALLEN	JULY 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED 3	APRIL 12, 1896	73	---	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER 21	SAME	RIDGEWAY, MISSOURI	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
W. H. ALLEN	OHIO	LUCY CLEMENTINE	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI 3	518-10-7535	Thomas Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Emphysema, pulmonary, chronic, obstructive. 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

492X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from JUNE 29, 19 69, to JULY 12, 19 69, and that death occurred at 4:10 a.m., from the causes and on the date stated above.

23a. SIGNATURE, DEGREE OR TITLE	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D. 597 /	VA CENTER, BOISE, IDAHO	7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial /	7-15-69	Dry Creek	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 17, 1969	Myrtle Palmer	Jack M. Green	E-528

FIRM NAME: Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM OH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 9 1969
NOV 2 5 2016

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3015
Local Reg. No. 83
Reg. Dist. No. 371

RECEIVED JUL 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): TWO DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1501 NORTH 26TH.

3. NAME OF DECEASED (Type or Print): a. (First) FRANK; b. (Middle) MARIAN; c. (Last) BROWNING

4. DATE OF DEATH: (Month) (Day) (Year) JULY 12, 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3

8. DATE OF BIRTH: OCTOBER 23, 1900

9. AGE (In years last birthday): 68
IF UNDER 1 YR. Months: — Days: —
IF UNDER 24 HRS. Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAIL HANDLER 08

10b. KIND OF BUSINESS OR INDUSTRY: U.S. POST OFFICE

11. BIRTHPLACE (State or foreign country): HEMSHURST, NEBRASKA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: OLIVER BROWNING
BIRTHPLACE: NEBRASKA

14. MOTHER'S MAIDEN NAME: ALBERTA FELLOWS
BIRTHPLACE: NEBRASKA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WWI 3

16. SOCIAL SECURITY NO.: 518-09-03-97

17. INFORMANT'S SIGNATURE: Thomas Bentley
ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of prostate with metastases — INTERVAL BETWEEN ONSET AND DEATH: 3 months +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY occur?

22. VA attended the deceased from JULY 11, 19 69, to JULY 12, 19 69, and that death occurred at 3:30p m., from the causes and on the date stated above.

23a. SIGNATURE (M.D. or title): Robert C. Lewis, M.D. 597
ROBERT C. LEWIS, M.D.

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-16-69

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park

24d. LOCATION (City, town, or county): Boise, (State) Idaho

DATE REC'D BY LOCAL REG.: 7-17-69

REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson

25. EMBALMER: G. W. Waters

LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3016
Local Reg. No. 467
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 24 1969 Bureau of Vital Stat. 319

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 19 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1721 Franklin Street

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): E.
c. (Last): OWINGS

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: March 24, 1902
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Librarian 06
10b. KIND OF BUSINESS OR INDUSTRY: city library
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel T. Owings — BIRTHPLACE: Maryland
14. MOTHER'S MAIDEN NAME: Sarah Swann — BIRTHPLACE: Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): ------ 0
16. SOCIAL SECURITY NO.: 518-36-0421
17. INFORMANT'S OWN SIGNATURE: Durahm, Calif. — ADDRESS: Tom S. Owings

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Irradiation necrosis terminal — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — ileum c̄ perforation.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) (Irradiation for CA left ovary)

DUE TO (c) 9 mo ago.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: necrosis ileum c̄ perforation.
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1960, *to* July 12, 1969, *that I last saw the deceased alive on* July 11, 1969, *and that death occurred at* 5:17 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 216 [signature] MD
23b. ADDRESS: 550 S Latah
23c. DATE SIGNED: 11 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7-15-69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: July 23, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-509

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Summers Funeral Home

DUTIES:

JUL 2 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 5 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3017
Local Reg. No. 477
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 JUL 25 1969 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Boise Bureau
c. LENGTH OF STAY (In this place): 1½ Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 431 South Curtis

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) EDNA c. (Last) PAUL

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Nov. 29, 1896

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Chesterfield, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nelson J. Hogan
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mary Josephine Bergeson
BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No. 2

16. SOCIAL SECURITY NO.: No.

17. INFORMANT'S OWN SIGNATURE: Wm Paul
ADDRESS: Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 36hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease — 5 yrs (10+ yrs)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — 10 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 11, 1969, *to* July 12, 1969, *that I last saw the deceased alive on* July 12, 1969, *and that death occurred at* 11:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 364 Paul F. Miner MD

23b. ADDRESS: 1333 W. Jefferson Boise, Idaho 83702

23c. DATE SIGNED: 7/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-16-1969

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: July 24, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Russell C. Relyea — LICENSE NO.: E-412

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3018
Local Reg. No. 466
Reg. Dist. No. 370

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 311
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 6302 Northview
d. STREET ADDRESS (If rural, give location): Boise, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): Lloyd
b. (Middle): L.
c. (Last): Scrivner

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 11, 1906
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 24 and Machinery
10b. KIND OF BUSINESS OR INDUSTRY: Salesman
11. BIRTHPLACE (State or foreign country): Vernon County, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ben R. Scrivner — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Emza Goodman — BIRTHPLACE: Illionois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 8
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Elwin L Scrivner — ADDRESS: Rt. 2 Meridian

18. CAUSE OF DEATH 2001
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): LYMPHOSARCOMA — INTERVAL BETWEEN ONSET AND DEATH: 1961 (8 yrs)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary Heart Disease — 3 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 7, 1969 *to* July 12, 1969, *that I last saw the deceased alive on* July 11, 1969, *and that death occurred at* 3:06 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 071 (Degree or title): M.D.
23b. ADDRESS: 848 La Cassia, Boise, Idaho
23c. DATE SIGNED: 7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-15-69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-16-69
REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson
25. EMBALMER: Geo Jerreal
LICENSE NO.: 366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 14 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3019
Local Reg. No. 478
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1604 North 27th.

3. NAME OF DECEASED (Type or Print): a. (First) CARRIE b. (Middle) c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 7, 1884

9. AGE (In years last birthday): 85
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): St. Edward, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph R. Sheldon — BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Henrietta Heberling — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. 2
(If yes, give war or dates of service): ----0----

16. SOCIAL SECURITY NO.: 519-07-8883-D

17. INFORMANT'S OWN SIGNATURE: Fred Smith — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease — several yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 10, 1969 *to* July 12, 1969, *that I last saw the deceased alive on* July 12, 1969, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul F. Miner M.D.

23b. ADDRESS: 1333 W. Jefferson St Boise, Idaho 83702

23c. DATE SIGNED: 7/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-15-69

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: July 24, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3020
Local Reg. No. 457
Reg. Dist. No. 270

BIRTH NO.

RECEIVED
JUL 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY IN THIS (this place): 45 Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route #3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THOMAS	C.	BROWN	July 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	May 20, 1903	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
President - Pumice 26	Products Co.	El Dorado, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas C. Brown	Canada	Deborah Hendershott	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes / 1922-1925	533-20-7461	Thama Brown	Rt.3, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Ruptured aortic aneurysm. 4419	1 week
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Atheno sclerosis of aorta	2 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Old myocardial infaction	6 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 10:30 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. R. Blackburn MD	Boise Ida.	14 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-16-69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Myrtle Palmer by Helen Olson	Lowell Newman	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

8 - 1 -

JUL 14 1969
JUL 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

DEC 18 1973
OCT 13 1992

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3021
Local Reg. No. 483
Reg. Dist. No. 270

BIRTH NO.

RECEIVED AUG 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 Year 101
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE California 05
b. COUNTY Los Angeles 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey
d. STREET ADDRESS (If rural, give location) 8717 Boyne Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Bernice b. (Middle) Adelia c. (Last) Mitchell

4. DATE OF DEATH (Month) (Day) (Year) 7-13-69

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH November 7, 1901
9. AGE (In years last birthday) 67
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Bailey, Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME B. H. Young BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary Wilmouth BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 518-28-5711A
17. INFORMANT'S OWN SIGNATURE X Robert L Mitchell ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1829

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CANCER OF UTERUS — INTERVAL BETWEEN ONSET AND DEATH 15 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-3-69, 19__, *to* 7-13, 1969, *that I last saw the deceased alive on* 7-13, 1969, *and that death occurred at* 12:30 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M M Rutherholder, M.D.
23b. ADDRESS 848 La Cassia, Boise, Idaho
23c. DATE SIGNED 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-15-69
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park
24d. LOCATION (City, town, or township) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. July 29 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER G. W. Waters G W Waters
LICENSE NO. E-461
FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JUL 25 1969
Bureau of Vital Statistics

State File No. 3022
Local Reg. No. 83
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 ADA 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 5 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 004 VETS ADMIN HOSPITAL, BOISE, IDA.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE OREGON 38 b. COUNTY MALHEUR 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NYSSA
d. STREET ADDRESS (If rural, give location) Box 323

3. NAME OF DECEASED (Type or Print) a. (First) WAYNE b. (Middle) OTTIS c. (Last) WATSON
4. DATE OF DEATH (Month) (Day) (Year) JULY 13, 1969

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED 4
8. DATE OF BIRTH OCTOBER 8, 1918
9. AGE (In years last birthday) 50 IF UNDER 1 YR. Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 27 LABORER & TRUCK DRIVER
10b. KIND OF BUSINESS OR INDUSTRY SAME
11. BIRTHPLACE (State or foreign country) WILLOW SPRINGS, MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ZACK WATSON BIRTHPLACE ARKANSAS
14. MOTHER'S MAIDEN NAME MARY F. BERRY BIRTHPLACE MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1 (If yes, give war or dates of service) WWII 4
16. SOCIAL SECURITY NO. 495-09-6951
17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH 1621
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchogenic carcinoma with metastases — INTERVAL BETWEEN ONSET AND DEATH 7 Months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from JULY 8, 1969, to JULY 13, 1969, and that death occurred at 7:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE 597 O. G. RIML, M.D. [signature] (Degree or title)
23b. ADDRESS VA CENTER, BOISE, IDAHO
23c. DATE SIGNED 7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7-13-69
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Nyssa, Oregon

DATE REC'D BY LOCAL REG. July 23, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-526
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3023
Local Reg. No. 468
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 18 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (In this place): 107 / 7 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1201 Euclid 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1201 Euclid

3. NAME OF DECEASED (Type or Print): a. (First) Lena b. (Middle) C. c. (Last) Craig

4. DATE OF DEATH: (Month) July (Day) 14, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 12/4/1888

9. AGE (In years last birthday): 80
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing 13

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): Falkstore, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.SA

13. FATHER'S NAME: Andrew Rasmussen — BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Stena Kesgard — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes / (If yes, give war or dates of service): WW1 3

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Louis Rasmussen — ADDRESS: New Plymouth

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Probable Cardiac Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Unk.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Emphysema — Unk.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

492X

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒ XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* As Coroner only, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__ *and that death occurred at* 715 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 E. Davis (Degree or title): Coroner 4

23b. ADDRESS: 3720 Meadow Dr., Boise

23c. DATE SIGNED: 7/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 17, 1969

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek

24d. LOCATION (City, town, or county): Boise, (State): Idaho

DATE REC'D BY LOCAL REG.: 7-18-69

REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson

25. EMBALMER: A. E. Alden

LICENSE NO.: E-435 299

FIRM NAME: Alden-Waggoner

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 1 8 1969
AUG 1 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 18 1969 Bureau of Vital Statistics

State File No. 3024
Local Reg. No 86
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho c. LENGTH OF (If not in this place): 800	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Home 235	d. STREET ADDRESS (If rural, give location): 1803 No. 28th

3. NAME OF DECEASED (Type or Print)	a. (First) Jens	b. (Middle) Peter	c. (Last) Jensen	4. DATE OF DEATH (Month) July (Day) 14, (Year) 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: Dec. 11, 1894	9. AGE (In years last birthday): 74 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self employed-grocery 22	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Hans Jensen	BIRTHPLACE: Denmark	14. MOTHER'S MAIDEN NAME: Karen	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 (If yes, give war or dates of service): W.W. I 3	16. SOCIAL SECURITY NO.: 505-18-0240	17. INFORMANT'S OWN SIGNATURE: x Viola E. Jensen	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Cerebrovascular Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 1, 1969, *to* July 14, 1969, *that I last saw the deceased alive on* July 14, 1969, *and that death occurred at* 8:05 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 333 [signature] (Degree or title)	23b. ADDRESS: 808 La Cerro Dr Boise	23c. DATE SIGNED: 7-18-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial /	24b. DATE: 7/17/69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: 7-28-69	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: A. E. Alden	LICENSE NO.: 299

FIRM NAME: Alden-Waggoner

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969

JUL 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 2 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3025
Local Reg. No. 476
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1002 E. Washington

3. NAME OF DECEASED (Type or Print): a. (First) Duncan (Duke) b. (Middle) Arthur c. (Last) Ross

4. DATE OF DEATH (Month) (Day) (Year): July 14, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 21, 1911

9. AGE (In years last birthday): 58
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Franklin P. Ross
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Anna R. Hatcher
BIRTHPLACE: Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 0
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 543-01-3322

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: 1002 E. Washington Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 2381 Brain Tumor

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 19 69 *to* July, 19 69 *that I last saw the deceased alive on* 7-14, 1969 *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23a. SIGNATURE 583 [signature] (Degree or title)

23b. ADDRESS 401 Latah St

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 18, 1969

24c. NAME OF CEMETERY OR CREMATORY: Parma Cemetery

24d. LOCATION (City, town, or county) (State): Parma, Idaho

DATE REC'D BY LOCAL REG.: July 23, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Kenneth E. Spencer

LICENSE NO.: E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3026
Local Reg. No. 480
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 28 1969 Bureau of Vital

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: BOISE CONVALESCENT CENTER 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 3511 Grover Court

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
E L V A	L A B R U M		July 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	never married	Dec. 23, 1896	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary 19	State and Federal	Meadow, Millard County, Utah	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry George Labrum	Cottonwood, Utah	Sarah Emma Greenhalgh	Meadow, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518 32 2974 A	X Emma L. Reading	2208 No 18th Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3 Aug 1966 *to* 15 July, 1969, *that I last saw the deceased alive on* 13 July, 1969, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J Hugh Atkinson MD	401 Idaho St Boise Ida	23 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 18, 1969	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 28 1969	Myrtle Palmer	Conway Grant Conway Grant	E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

500.

JUL 2 8 1969

SEP 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 2 5 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3027
Local Reg. No. 86
Reg. Dist. No. 371

BIRTH NO.

RECEIVED JUL 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA 01 309
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
LENGTH OF STAY (In this place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VAH BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY JEROME 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) JEROME
d. STREET ADDRESS (If rural, give location) RT. 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GEORGE	C.	PADGETT	JULY 15 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	DIVORCED 4	JUNE 11, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER 06	SAME	SOUTH PITTSBURG, TENNESSEE	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
ISAAC PADGETT	ILLINOIS	KELLY HELMS	TENNESSEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE	ADDRESS
YES	WWII 4	518 30 19 05	Edmund Smiley	V.A. HOSPITAL RECORDS, BOISE, IDAHO

4169

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable ventricular fibrillation. — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary occlusion.
DUE TO (c) Arteriosclerosis, generalized. — Years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Peripheral arteriosclerosis with ischemia, leg. — 3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/8/69 7/10/69	Translumbar aortogram Lumbar sympathectomy	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
V.A. m.		

22. I hereby certify that I attended the deceased from July 6, 1969, to July 15, 1969, that I last saw the deceased alive on and that death occurred at 6:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. W. Carson for ROBERT J. BUNGARD, M.D. 597		VA HOSPITAL, BOISE, IDAHO	7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	25. EMBALMER	LICENSE NO.
Removal 3	7-15-1969		Jerome, Idaho	L. E. Alden	299

DATE REC'D BY LOCAL REG. 7-18-69
REGISTRAR'S SIGNATURE Myrtle Palmer by Helen Olson
FIRM NAME: Alden-Waggoner

Federal Security Agency
United States Public Health Service FORM PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969
JUL 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 1 3 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. NOV 1 8 1974
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3028
Local Reg. No. 484
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011 302	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise — LENGTH OF STAY (In this place) 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002	d. STREET ADDRESS (If rural, give location) 6108 Everett St.

3. NAME OF DECEASED (Type or Print) a. (First) GERTRUDE	b. (Middle)	c. (Last) JACOBS	4. DATE OF DEATH (Month) (Day) (Year) July 17, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH 7-9-1912	9. AGE (In years last birthday) 57 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Carter Co., Kentucky	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carroll	BIRTHPLACE Kentucky	14. MOTHER'S MAIDEN NAME Anna Carroll	BIRTHPLACE Kentucky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 519-48-5024	17. INFORMANT'S OWN SIGNATURE X Wayne A Jacobs	ADDRESS	

1829

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Adenocarcinoma of uterus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 648 David M. Barton M.D. (Degree or title)	23b. ADDRESS Boise Idaho	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE July 21, 1969	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. July 29 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER G.W. Waters G.W. Waters	LICENSE NO. E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3029
Local Reg. No. 487
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 011 Ada 206	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 5½ Mo.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 332 Boise Convalescent Center	d. STREET ADDRESS (If rural, give location) 1006½ Main Street

3. NAME OF DECEASED (Type or Print)	a. (First) RAWLA	b. (Middle) A.	c. (Last) MILLER	4. DATE OF DEATH (Month) (Day) (Year)	July 17, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4	8. DATE OF BIRTH Dec. 14, 1886	9. AGE (In years last birthday) 82	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical 21	10b. KIND OF BUSINESS OR INDUSTRY auto engineer	11. BIRTHPLACE (State or foreign country) Centerville, Oregon	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) --0	16. SOCIAL SECURITY NO. 519-12-0310	17. INFORMANT'S OWN SIGNATURE Frank C. Towell	ADDRESS 517 Haines Boise, Idaho		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4121

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Anterior Cristic Heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Perfusion disease
DUE TO (c) Cardiac Decompensation

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___ that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 306 [signature]	(Degree or title) MD	23b. ADDRESS Boise Ida	23c. DATE SIGNED 7-23-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-19-69	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. July 30 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Robert G. Ross	LICENSE NO. E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 14 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3030
Local Reg. No. 85
Reg. Dist. No. 371

BIRTH NO.

RECEIVED JUL 29 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: ADA 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE — LENGTH OF STAY (In this place): 69 days 302	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): V.A.HOSPITAL, BOISE, IDAHO 004	d. STREET ADDRESS (If rural, give location): 2403 CANAL STREET

3. NAME OF DECEASED (Type or Print) a. (First): JOHN	b. (Middle): C.	c. (Last): SCHULZE	4. DATE OF DEATH (Month) (Day) (Year): JULY 17, 1969	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3	8. DATE OF BIRTH: MAY 11, 1891	9. AGE (In years last birthday): 78 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER 29	10b. KIND OF BUSINESS OR INDUSTRY: FARMING	11. BIRTHPLACE (State or foreign country): HALSTEAD, KANSAS	12. CITIZEN OF WHAT COUNTRY?: U.S.A.	
13. FATHER'S NAME: AUGUST SCHULZE	BIRTHPLACE: GERMANY	14. MOTHER'S MAIDEN NAME: KATHERINE WEICHMANN	BIRTHPLACE: GERMANY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES 1 — (If yes, give war or dates of service): WWI 3	16. SOCIAL SECURITY NO.: 518 44 5358	17. INFORMANT'S OWN SIGNATURE: Jamie D. Bentley	ADDRESS: V.A.HOSPITAL RECORDS, BOISE, IDAHO	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5900

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Chronic pyelonephritis	2 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic brain syndrome ASHD with atrial fibrillation	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) V.A. m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. ~~Thereby certify that I~~ attended the deceased from May 9, 1969, to July 17, 1969, ~~[illegible]~~ ~~[illegible]~~, and that death occurred at 5:55 A m., from the causes and on the date stated above.

23a. SIGNATURE: ROBERT C. LEWIS, M.D. 597 (Degree or title)	23b. ADDRESS: VAC, BOISE, IDAHO	23c. DATE SIGNED: 7-17-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: 7-21-69	24c. NAME OF CEMETERY OR CREMATORY: Meridian	24d. LOCATION (City, town, or county) (State): Meridian Idaho
DATE REC'D BY LOCAL REG.: July 25, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Geo Jerread	LICENSE NO.: 366

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 2 1969

APR 1 5 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. H.E. Allen 342-8221
220 N1

Certificate of Death

STATE OF IDAHO

State File No. 3031
Local Reg. No. 482
Reg. Dist. No. 370

RECEIVED AUG - 1 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convelesent 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 2010 Arcadia

3. NAME OF DECEASED (Type or Print)
a. (First) Ingeleiv
b. (Middle)
c. (Last) Rogde

4. DATE OF DEATH (Month) July (Day) 18 (Year) 1969

5. SEX female
6. COLOR OR RACE caue.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH May 3, 1883
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Webster Hargandon, Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Svin Krakivik — BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Mansakar — BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 3 — (If yes, give war or dates of service) No 0
16. SOCIAL SECURITY NO. 518-60-3805
17. INFORMANT'S OWN SIGNATURE X Gary Rogde — ADDRESS Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) General arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 15, 1968, *to* July 18, 1969, *that I last saw the deceased alive on* July 16, 1969, *and that death occurred at* 9:20 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 005 Howard E. Allen 1
23b. ADDRESS 220 N. 1st St.
23c. DATE SIGNED 7/22/1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 7-22-69
24c. NAME OF CEMETERY OR CREMATORY Morris Hill
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. July 28, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Daniel G. Gibson — LICENSE NO. 400
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 16 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 04 2007

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 28 1969 Bureau of Vital Statistics

State File No. 3032
Local Reg. No. 481
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 2 Weeks 3/4	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 408 O'Farrell

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)	
MARK	WILLIAM	DYETT	July 19, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: March 31, 1900	9. AGE (In years last birthday): 69; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assistant Manager 26	10b. KIND OF BUSINESS OR INDUSTRY: Salt Lake Hardware	11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Wm Barnes Dyett	BIRTHPLACE: Scotland	14. MOTHER'S MAIDEN NAME: Isabell Simpson	BIRTHPLACE: England	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1	(If yes, give war or dates of service): Peacetime 0	16. SOCIAL SECURITY NO.: 519-09-9767-A	17. INFORMANT'S OWN SIGNATURE: May Violet Dyett	ADDRESS: Idaho

4109

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: ± 2 wks

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.: Congestive heart failure.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/26, 1968, *to* 11/11, 1969, *that I last saw the deceased alive on* 11/11, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 095 Callahan, M.D. 1	23b. ADDRESS: Boise Idaho	23c. DATE SIGNED: 7/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: July 22, 1969	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise Ada Idaho
DATE REC'D BY LOCAL REG.: July 28 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Eldon T. Pearson	LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

2 cc.

JUL 2 8 1969
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SEP 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3033
Local Reg. No. 504
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Ada 01 — 403

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (In this place): 2½ hours

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho — b. COUNTY: Ada 01

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 2723 West Jefferson St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
E.	DOYLE	MANSUR	July 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Dec. 10, 1914	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bus. Manager-Paving Dept. 26	Morrison-Knudson	Mosquero, New Mexico	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ray Mansur	Oklahoma	Rowena Hill Mansur	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	8	542-12-4191	X Mrs Adaris Mansur	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary ~~arteriosclerosis thrombosis~~ — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Boise, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
7/19/69 m.		

22. *I hereby certify that I attended the deceased from* 7/19/69, 19____, *to* 7/19/69, 19____, *that I last saw the deceased alive on* 7/19/69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
557 David Welch MD	110 North Latah	8 1 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-23-69	CLOVERDALE MEMORIAL PARK	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5, 1969	Myrtle Palmer	G.W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG - 5 1969

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JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 6 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3034
Local Reg. No. 87
Reg. Dist. No. 371

BIRTH NO.

RECEIVED AUG - 1969 Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 34 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO
b. COUNTY CASSIA 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BURLEY
d. STREET ADDRESS (If rural, give location) 2478 NORMAL

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ARLIE	W.	SMITH	JULY 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED 3	FEBRUARY 3, 1900	69	— / —	— / —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MEAT CUTTER 21	BUTCHER	BEDFORD, IOWA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
NICK SMITH	WISCONSIN	ROSABELLE HITTLE	INDIANA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII 4	526-07-9350	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Shock, post operative, following cholecystectomy	3hr.45min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute exacerbation of chronic pancreatitis with abscess formation.	Unknown
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic heart disease	Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-18-69	Calculus Cholecystitis	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I attended the deceased from JUNE 16, 1969, to JULY 20, 1969, and last saw deceased alive on JULY 20, 1969, at 9:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
WAYNE G. CROOKSTON, M.D. 397		VA CENTER, BOISE, IDAHO	7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7-21-69		Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 30, 1969	Myrtle Palmer	[signature]	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DR-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3035
Local Reg. No. 488
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 1 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (rural)
d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print): a. (First) GLORIA b. (Middle) V. c. (Last) BRUCKNER

4. DATE OF DEATH (Month) (Day) (Year): July 21, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 31, 1907

9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Graylock, Mass.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Vincelette
BIRTHPLACE: Quebec, Canada

14. MOTHER'S MAIDEN NAME: Josephine Ducharme
BIRTHPLACE: Ontario, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 2 8199

16. SOCIAL SECURITY NO.: 371 22 1245

17. INFORMANT'S OWN SIGNATURE: Mrs. V. Bruckner
ADDRESS: Rt. 1 Jerome, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute sub dural hematoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Automobile accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fx rib, pneumothorax

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION: 7/19/69

19b. MAJOR FINDINGS OF OPERATION: Acute sub dural hematoma, pneumothorax

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/19, 19 69, *to* 7/21, 19 69, *that I last saw the deceased alive on* 7/21, 19 69 *and that death occurred at* 3:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: 616 Eastman Bldg. Boise

23c. DATE SIGNED: 7/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 24, 1969

24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery

24d. LOCATION (City or town, county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: July 30 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Howell Mortuary

LICENSE NO.: E-509 ESG

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3036
Local Reg. No. 485
Reg. Dist. No. 270

BIRTH NO.

RECEIVED AUG - 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 402
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2915 Innis Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Catherine b. (Middle) Lynn c. (Last) Fullington

4. DATE OF DEATH: July 21, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 8, 1949

9. AGE (In years last birthday): 20
IF UNDER 1 YEAR: Months 3 Days 13
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Montreal, Canada

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Guy Campbell
BIRTHPLACE: Sheridan, Missouri

14. MOTHER'S MAIDEN NAME: Lois Monroe
BIRTHPLACE: Moncton, New Brunswick Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-58-5546

17. INFORMANT'S OWN SIGNATURE: X [illegible] Fullington
ADDRESS: 2915 Innis st Boise

8799

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Ground Irreversible Shock
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Scalp Laceration, severe
DUE TO (c): Fracture Right Humerus
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Head Injury

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): XX 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP): 010 (COUNTY): 13 (STATE): Ada County, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-21-69 a m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Single car accident

22. *I hereby certify that I attended the deceased from* 7/21, 1969, *to* 7/21, 1969, *that I last saw the deceased alive on* 7/21, 1969, *and that death occurred at* 3:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Bruce Moody (Degree or title): MD
23b. ADDRESS: 2429 N. Cole Rd
23c. DATE SIGNED: 7/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-25-1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: July 29 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3037
Local Reg. No. 489
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1123 3rd Street North

3. NAME OF DECEASED (Type or Print): a. (First) Edward b. (Middle) Eugene "Eddie" c. (Last) Mayes

4. DATE OF DEATH: (Month) (Day) (Year): July 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 27, 1941

9. AGE (In years last birthday): 27
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27

10b. KIND OF BUSINESS OR INDUSTRY: Trailer Hauling

11. BIRTHPLACE (State or foreign country): Nampa, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dale E. Mayes
BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Helen L. Hennessey
BIRTHPLACE: Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 505 54 4586

17. INFORMANT'S OWN SIGNATURE: x Bill Hennessey
ADDRESS: Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Basel Skull Fracture. & brain. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Ruptured Lung. Fractured right diapragm. — Brief
DUE TO (c): D-C-A.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): ACCIDENT

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?: Auto Roll over.

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 1:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 583 E. Davis 4 Coroner

23b. ADDRESS: Boise, Idaho 3720 Meadow Dr.

23c. DATE SIGNED: 7-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-24-69

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: July 30 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 8 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 8 1993

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3038
Local Reg. No. 84
Reg. Dist. No. 371

BIRTH NO.

RECEIVED

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 ADA JUL 25 1969 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) V.A. HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) Idaho State Veterans Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	B.	TRACY	July 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	SINGLE	AUGUST 28, 1891	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER 06	SAME	MACEDONIA, IOWA	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOEL TRACY	IOWA	ALICE GROFF	IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE	ADDRESS
YES	WWI 3	542-03-09-29	VA HOSPITAL RECORDS, BOISE, IDAHO	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute myocardial infarction.	1 wk.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease.	unknown.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Encephalopathy due to alcoholism.	unknown.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. V.A. attended the deceased from July 16, 19 69, to July 21, 19 69, and that death occurred at 10:25a m., from the causes and on the date stated above.

23a. SIGNATURE, (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D. 397	VAC, BOISE, IDAHO	7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7/21/1969	LaGrande, Oregon	LaGrande, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 24, 1969	Myrtle Palmer	Earl Waggoner	E-299

Federal Security Agency
United States Public Health Service FORM DR-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3039
Local Reg. No. 479
Reg. Dist. No. 370

RECEIVED JUL 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 305
b. CITY OR TOWN: Boise
c. LENGTH OF STAY in this place: 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Baker 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baker
d. STREET ADDRESS (If rural, give location): 2695½ 6th Street

3. NAME OF DECEASED (Type or Print): a. (First) Darnell; b. (Middle); c. (Last) Cook

4. DATE OF DEATH: (Month) July (Day) 22, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 3, 1899

9. AGE (In years last birthday): 70 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer 22

10b. KIND OF BUSINESS OR INDUSTRY: Retail Grocery

11. BIRTHPLACE (State or foreign country): South Haven, Michigan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter J. Cook — BIRTHPLACE: Keeler, Michigan

14. MOTHER'S MAIDEN NAME: Minnie E. Clark — BIRTHPLACE: Silver Creek, Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): 2 0

16. SOCIAL SECURITY NO.: 541-10-0284

17. INFORMANT'S OWN SIGNATURE: Esta Cook — ADDRESS: Baker, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4489

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Uremia - Urinary Calculi

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 17, 1969 *to* July 22, 1969, *that I last saw the deceased alive on* July 21, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: 259 B.B. Jefferson (Degree or title): MD

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 25, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery

24d. LOCATION (City, town, or county) (State): Baker, Oregon

DATE REC'D BY LOCAL REG.: July 25, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Earl Waggoner — LICENSE NO.: E-422

FIRM NAME: The Beatty Chapel, Baker, Oregon

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3040
Local Reg. No. 470
Reg. Dist. No. 370

BIRTH NO. JUL 25 1969

1. PLACE OF DEATH a. COUNTY Bureau of Vital Statistics Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location) 316 Clithero Dr.

3. NAME OF DECEASED (Type or Print)	a. (First) Roy	b. (Middle) John	c. (Last) Givart	4. DATE OF DEATH (Month) (Day) (Year) July 22, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH Dec. 19, 1903	9. AGE (In years last birthday) 65 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook 01	10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfons Givart	BIRTHPLACE Belgium	14. MOTHER'S MAIDEN NAME Rosie Joplin	BIRTHPLACE Boise, Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 518-09-1984	17. INFORMANT'S OWN SIGNATURE Mildred Givart	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

491X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic obstructive bronchitis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Obstructive Carcinoma colon

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 6-26-'69	19b. MAJOR FINDINGS OF OPERATION Mucocarcinoma Transverse colon	20. AUTOPSY? Yes ☑ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-24-'69, *to* 7-21-'69, *that I last saw the deceased alive on* 7-21-'69, *and that death occurred at* 4 a *m., from the causes and on the date stated above.*

23a. SIGNATURE 268 Ernest N. Jones Jr. MD (Degree or title)	23b. ADDRESS Boise	23c. DATE SIGNED 7-25-'69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/25/1969	24c. NAME OF CEMETERY OR CREMATORY Joplin Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. July 24, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Paul Waggoner	LICENSE NO. E-422

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
AUG - 4 1969
Bureau of Vital Statistics

State File No. 3041
Local Reg. No. 485
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke 002 302

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Oregon 38
b. COUNTY: Baker 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baker
d. STREET ADDRESS (If rural, give location): West Campbell Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Kevin	Mark	Henry	7	22	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Sept. 7, 1962	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	Grade School	Nampa, Idaho	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Byron Henry		Becky Mark	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2 8	None	Byron Henry	Baker, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — 906X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Increased intracranial pressure.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Edema
DUE TO (c) Severe Headaches + Skull F/X.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Respiratory obstruction

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 7/22/69
19b. MAJOR FINDINGS OF OPERATION: Tracheotomy — Dr. A.C. Jones Jr. M.D.
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	in or about home	Baker 38 555 Oregon

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
7-21-69 m.		Pt thrown from a horse

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward Kuper M.D	616 Eastman Bldg	7/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-25-69	Mt. Hope Cemetery	Baker, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1 1969	Myrtle Palmer	A. Dale McMurtrey	

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DR-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 3042
Local Reg. No. 471
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada JUL 25 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1113 Ranch Road

3. NAME OF DECEASED (Type or Print) a. (First) Melda b. (Middle) Marie c. (Last) Johnson
4. DATE OF DEATH (Month) July (Day) 22, (Year) 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 13
8. DATE OF BIRTH Feb. 3, 1908
9. AGE (In years last birthday) 61 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Girl's Counselor 12
10b. KIND OF BUSINESS OR INDUSTRY Public Schools
11. BIRTHPLACE (State or foreign country) Payette, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Albert Mohler BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Lucy Ethel Gorham BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 518-09-9109
17. INFORMANT'S OWN SIGNATURE Boyd E. Johnson ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5900

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic Renal Insufficiency — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Pyelonephritis — 8 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Essential Hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 18, 1966, to July 22, 1969, that I last saw the deceased alive on July 21, 1969, and that death occurred at 6:35 a.m., from the causes and on the date stated above.

23a. SIGNATURE George R. Baker, MD (Degree or title)
23b. ADDRESS 131 East Idaho, Boise
23c. DATE SIGNED 7/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/25/1969
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. July 24, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER A. E. Alden
LICENSE NO. E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 25 1969
JUL 28 1969
AUG 5 1969
MAR 10 1970
NOV 17 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3043
Local Reg. No. 490
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 72 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) NELLIE
b. (Middle) BESSIE
c. (Last) FERGUSON

4. DATE OF DEATH (Month) (Day) (Year) July 23, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 29, 1886
9. AGE (In years last birthday) 83 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Payette, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Applegate, BIRTHPLACE Umatilla Co., Oregon
14. MOTHER'S MAIDEN NAME Mary M. E. King, BIRTHPLACE Winona, Mississippi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 518-26-9155
17. INFORMANT'S OWN SIGNATURE Mrs Lela Phillips ADDRESS 9203 Overland Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4412

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Rupture Abd. Aortic Aneurysm - 2 h.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 1965 *to* July 23, 1969, *that I last saw the deceased alive on* July 21, 1969, *and that death occurred at* 6:40 PM *from the causes and on the date stated above.*

23a. SIGNATURE Robert Frazier, MD (Degree or title) 176
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 7.28.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 7-26-69
24c. NAME OF CEMETERY OR CREMATORY Applegate-Kennedy
24d. LOCATION (City, town, or county) (State) Payette County, Idaho

DATE REC'D BY LOCAL REG. July 30, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Robert G. Ross
LICENSE NO. E-497

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3044
Local Reg. No. 514
Reg. Dist. No. 370

RECEIVED
AUG 13 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 5 Weeks 201
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 611 Ash Street

3. NAME OF DECEASED (Type or Print)
a. (First): MAMIE
b. (Middle): LOUISE
c. (Last): LUNDBERG

4. DATE OF DEATH (Month) (Day) (Year): July 23, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 28, 1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months - Days - IF UNDER 24 HRS.: Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Coulter — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Mary Matilda Cochran — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): - - 0
16. SOCIAL SECURITY NO.: 518-09-6651
17. INFORMANT'S OWN SIGNATURE: Hazel E. Lacey — ADDRESS: 5316 Adelaide Way, Sacramento, California

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Florid Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: progressive

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Alcoholism — Long term
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Uremia — progressive

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-14, 1969, *to* 7-23, 1969, *that I last saw the deceased alive on* July 23, 1969, *and that death occurred at* 10:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 318 (Degree or title) 1
23b. ADDRESS: 401 Boardwalk Boise Ida
23c. DATE SIGNED: 8/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: July 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county): Payette (State): Idaho

DATE REC'D BY LOCAL REG.: Aug 6 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG - 4 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3045
Local Reg. No. 496
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette 380
d. STREET ADDRESS (If rural, give location) 920 N. 4th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Fred	R.	Babbit	7	24	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	widowed 2	3/16/1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher 04	agriculture	Cromwell, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Milton J. Babbit	----	Lorena B. Wright	------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		4709	William R. Babbit	Payette, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Thrombosis	1-2 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Severe Generalized Arterio Sclerosis	5 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Congestive Heart Fail	1 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 4-17-, 1969, to 7-24-, 1969, that I last saw the deceased alive on 7-24-, 1969, and that death occurred at 5 12 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
393	Boise Idaho	7/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
rem. burial	7/26/69	Hillcrest Cemetery	Weiser Washington Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1 1969	Myrtle Palmer	R. Lee Remmen	E 388

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 3046
Local Reg. No. 501
Reg. Dist. No. 370

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY Ada 011 AUG - 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau of V
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3806 Mt. View Drive

3. NAME OF DECEASED (Type or Print)
a. (First) Thomas
b. (Middle) Damion
c. (Last) Quinn

4. DATE OF DEATH (Month) July (Day) 24 (Year) 69

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 1, 1890
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy construction 11
10b. KIND OF BUSINESS OR INDUSTRY same
11. BIRTHPLACE (State or foreign country) Garden Valley, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Maurice Quinn — BIRTHPLACE Mass.
14. MOTHER'S MAIDEN NAME Mary Ann Brainard — BIRTHPLACE Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1 — (If yes, give war or dates of service) WWI 3
16. SOCIAL SECURITY NO. 1538
17. INFORMANT'S OWN SIGNATURE Mrs Eva A. Quinn — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) METASTATIC CANCER OF COLON — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 20, 1969, *to* July 24, 1969, *that I last saw the deceased alive on* July 24, 1969, *and that death occurred at* 11 45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 071 W M Rudolph Day, M.D. 1
23b. ADDRESS 848 La Cassia, Boise, Idaho
23c. DATE SIGNED 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE July 29, 69
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. Aug. 4, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Erle B. Byram — LICENSE NO. E-533

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home
342-8221

AUG - 4 1969

SEP 17 1969

FEB 10 1970

DEC 14 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3047
Local Reg. No. 88
Reg. Dist. No. 371

RECEIVED AUG - 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 39 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 4405 KENDALL

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EMERSON	L.	RICHARDS	JULY 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED 3	9-17-16	52	— / —	— / —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
WELDER 21	SAME	UNION, UTAH	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
LEO RICHARDS	UTAH	INA LYNN	UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII 4	518-10-3462	Thomas Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Lymphoma. — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from JUNE 16, 1969, to JULY 25, 1969 [illegible], and that death occurred at 2:05a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
FRED B. HINE, M.D. 597 Fred B. Hine MD	VA CENTER, BOISE, IDAHO	7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-28-69	Morris Hill	Boise Ida

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1 1969	Myrtle Palmer	Conway Grant	E478

FIRM NAME: Kelsea Mort.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 5 1969

APR 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3048
Local Reg. No. 497
Reg. Dist. No. 270

BIRTH NO.

RECEIVED AUG - 4 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (In this place): 1 Day

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 210 Hannan Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Herold	—	Darden	July 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Dec. 28, 1901	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Heavy Equipment Operator 11	Construction	Joplin, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clarence F. Darden	Missouri	Lula Robertson	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 2	0	519-24-8328	X Mildred Darden	Boise Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	4123 Acute Decompensation	2 Days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Coronary	10 yrs
DUE TO (c)	Old Myocardial Infarcts	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Chronic Brain Syndrome (Trauma) 1965	4 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Autopsy St Lukes Boise	Yes X No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 26 19 69 *to* July 26 19 69 *that I last saw the deceased alive on* July 26 19 69 *and that death occurred at* 9:47 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] M.D.	Boise Idaho	7/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	7-30-1969	Cloverdale Memorial Park	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1 1969	Myrtle Palmer	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG - 4 1969

AUG 5 1969

FEB 2 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items ~~17,~~ 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

69-7574 BIRTH NO.

RECEIVED AUG 8 1969 Bureau of Vital Statistics

343-4281 State File No. 3049
Local Reg. No. 507
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital 002
d. STREET ADDRESS (If rural, give location): 125 Bacon Dr.

3. NAME OF DECEASED (Type or Print): a. (First) ANNA b. (Middle) --- c. (Last) Wyman

4. DATE OF DEATH: (Month) July (Day) 26, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Infant	July 26, 1969	--	--- / ---	--- / 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
02		Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jon N. Wyman	Boise, Idaho	Mardee A. Hough	Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
No 2 0		Jon N. Wyman

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) hyaline membrane anoxia — INTERVAL BETWEEN ONSET AND DEATH: 1½ hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) malformation of placenta

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

7708

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-26, 1969, *to* 7-26, 1969, *that I last saw the deceased alive on* 7-26-69, 19____, *and that death occurred at* P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	200 E Bannock St	8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/29/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5 1969	Myrtle Palmer	Alden-Waggoner Chapel	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
AUG 20 1969

Certificate of Death

STATE OF IDAHO

State File No. 3050
Local Reg. No. 93
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH 010
a. COUNTY Ada - Boise-Ada Co. line
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ½ mile off Highway 21 on Arrowrock Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home Air Force Base, Ida
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) RONALD
b. (Middle) ELMER
c. (Last) BITTERS

4. DATE OF DEATH (Month) (Day) (Year) July 27, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH Oct. 25, 1949
9. AGE (In years last birthday) 19 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Air Force 05
10b. KIND OF BUSINESS OR INDUSTRY Government
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elmer L. Bitters — BIRTHPLACE (NA)
14. MOTHER'S MAIDEN NAME June C. (NA) — BIRTHPLACE (NA)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1 — (If yes, give war or dates of service) June 23, 1967 0
16. SOCIAL SECURITY NO. 500-52-9087
17. INFORMANT'S OWN SIGNATURE UNITED STATES AIR FORCE — ADDRESS Mountain Home Idaho

8169

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Head & Brain Injuries, Broken Neck. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7 27 69 2IOP m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Lost Control Auto. Rolled over. open top Auto.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 2IOP *m., from the causes and on the date stated above.*

23a. SIGNATURE 583 [signature] (Degree or title) Coroner 4
23b. ADDRESS 3720 Meadow Drive, Boise.
23c. DATE SIGNED 8-8-69.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE July 29, 1969
24c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery
24d. LOCATION (City, town, or county) St. Louis (State) Missouri

DATE REC'D BY LOCAL REG. Aug. 18 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Robert G. Ross
LICENSE NO. E-497

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 21X 1969

SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3051
Local Reg. No. 492
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 1 1969 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 100 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2106 North Beach Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2106 North Beach Street

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) OLIVER c. (Last) EVANS

4. DATE OF DEATH (Month) July (Day) 27, (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 25, 1886
9. AGE (In years last birthday) 83
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10
10b. KIND OF BUSINESS OR INDUSTRY Santa Fe Railroad
11. BIRTHPLACE (State or foreign country) Hanover Co., Penn.
12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME John Thomas Evans, BIRTHPLACE Penn.
14. MOTHER'S MAIDEN NAME Betty Watkins, BIRTHPLACE Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I 3
16. SOCIAL SECURITY NO. 709-14-6629
17. INFORMANT'S OWN SIGNATURE Amber Ryan Evans ADDRESS 2106 N. Beach Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/10/64, 19__, to 7/27, 1969, that I last saw the deceased alive on 7/27, 1969, and that death occurred at 5A m., from the causes and on the date stated above.

23a. SIGNATURE 368 Bruce Moody (Degree or title) M.D.
23b. ADDRESS 2429 N. Cole Rd
23c. DATE SIGNED 7/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-30-69
24c. NAME OF CEMETERY OR CREMATORY Cloverdale
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. Aug. 1 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Robert G. Ross
LICENSE NO. E-497
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG - 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....
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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3052
Local Reg. No. 89
Reg. Dist. No. 371

BIRTH NO.

AUG - 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 011 ADA	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY ELMORE 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE c. LENGTH OF STAY (In this place) 301 1 DAY	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) GLENNS FERRY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 004 VETS ADMIN HOSPITAL, BOISE, IDA.	d. STREET ADDRESS (If rural, give location) 505 WEST MADISON

3. NAME OF DECEASED (Type or Print)	a. (First) ELMER	b. (Middle) M.	c. (Last) JONES	4. DATE OF DEATH (Month) (Day) (Year) JULY 27, 1969
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	8. DATE OF BIRTH OCTOBER 17, 1896	9. AGE (In years last birthday) 72 — IF UNDER 1 YR. Months — Days — IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 04	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) WEISER, IDAHO	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANDREW JONES	BIRTHPLACE ARKANSAS	14. MOTHER'S MAIDEN NAME IENA ZUMWALT	BIRTHPLACE ARKANSAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1	(If yes, give war or dates of service) WWI 3 4109	16. SOCIAL SECURITY NO. 544-20-8972	17. INFORMANT'S OWN SIGNATURE Jamie Bentley VA HOSPITAL RECORDS, BOISE, IDAHO	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarct, acute. — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from JULY 26, 1969, to JULY 27, 1969, and that death occurred at 12:30 am from the causes and on the date stated above.

23a. SIGNATURE Wm. W. Laxson, M.D. (Degree or title) WM. W. LAXSON, M.D. 597	23b. ADDRESS VA CENTER, BOISE, IDAHO	23c. DATE SIGNED 7-28-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 30, 1969	24c. NAME OF CEMETERY OR CREMATORY Mann Creek Cem.	24d. LOCATION (City, town, or county) (State) Weiser Washington Idaho
DATE REC'D BY LOCAL REG. Aug. 1, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Alfred McMurphey	LICENSE NO. E-410

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3053
Local Reg. No. 530
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): Lot 23, Meadows Tr. Ct.

3. NAME OF DECEASED (Type or Print)
a. (First): GARY
b. (Middle): ALAN
c. (Last): TALLAKSON

4. DATE OF DEATH (Month) (Day) (Year): July 27, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 22, 1948
9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Air Force 05
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Irwin W. Tallakson — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Byreme M. Johnson — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): June 25, 1967 0
16. SOCIAL SECURITY NO.: 475-56-9273
17. INFORMANT'S OWN SIGNATURE: Mae Irwin Tallakson — ADDRESS: Willmar Minnesota

8169

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Head & Brain Injuries, Broken Neck. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 27 69 210P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Lost Control Auto. Rolled over. open top Auto.

22. *I hereby certify that I attended the deceased from* Did Not See Alive *19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at* 210P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 [signature] (Degree or title): Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 8-8-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: Cloverleaf Cemetery
24d. LOCATION (City, town, or county) (State): Willmar Minnesota

DATE REC'D BY LOCAL REG.: Aug. 18, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Robert G. Ross — LICENSE NO.: E-497

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

DUTIES:

AUG 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3054
Local Reg. No. 498
Reg. Dist. No. 370

BIRTH NO.

AUG - 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 011 Ada 301	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 1 Day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location) 825 East Jefferson Street

3. NAME OF DECEASED (Type or Print)	a. (First) JOHN	b. (Middle) EDWARD	c. (Last) GARRETT	4. DATE OF DEATH (Month) (Day) (Year) July 28, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH Dec. 12, 1904	9. AGE (In years last birthday) 64 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender - Happy Time Tavern 23	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ogden, Utah	12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Jack Garrett, Laramie, Wyoming	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Sarah Smith	BIRTHPLACE Nebraska	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2	(If yes, give war or dates of service) --0	16. SOCIAL SECURITY NO. 518-07-6146	17. INFORMANT'S OWN SIGNATURE Mrs John E. Garrett	ADDRESS 825 E. Jefferson Boise, Ida

887X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Fat Embolism — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture, left hip
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident 1	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) unknown	21c. (CITY, TOWN, OR TOWNSHIP) Boise, 13	(COUNTY) 010 Ada (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Feb. 1965, 19__, *to* July 28, 19 69, *that I last saw the deceased alive on* July 28, 19 69, *and that death occurred at* 5:00 a *m., from the causes and on the date stated above.*

23a. SIGNATURE 039 Max L. Ball, M.D. 1 (Degree or title)	23b. ADDRESS Boise, Idaho	23c. DATE SIGNED 7/30/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7-31-69	24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Aug. 1, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Norwell S. Demaray	LICENSE NO. E-509

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 5 1969
SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED AUG 19 1969

STATE OF IDAHO

State File No. 3055
Local Reg. No. 528
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 308
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 8 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): 316 E. Elm St.

3. NAME OF DECEASED (Type or Print)
a. (First): BESSIE
b. (Middle): MARIE
c. (Last): LANE

4. DATE OF DEATH (Month) (Day) (Year): July 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 12, 1907
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months – Days – IF UNDER 24 HRS.: Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Elmo, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Friedley — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Louise Ryff — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): - - 0
16. SOCIAL SECURITY NO.: 519-16-9618
17. INFORMANT'S OWN SIGNATURE: Catherine D. Hingsgiles — ADDRESS: Fruitland, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Brain Stem Compression — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Head Injury
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE XX (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): New Plymouth Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-20-69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Fell at home

22. *I hereby certify that I attended the deceased from* July, 1969, *to* July 28 1969, *that I last saw the deceased alive on* July 28, 1969, *and that death occurred at* 4:05P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 583 [signature] 4
23b. ADDRESS: 401 Idaho - Boise, Idaho
23c. DATE SIGNED: 8/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 31, 1969
24c. NAME OF CEMETERY OR CREMATORY: Park View
24d. LOCATION (City, town, or county) (State): New Plymouth Idaho

DATE REC'D BY LOCAL REG.: Aug. 18 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 6 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3056
Local Reg. No. 90
Reg. Dist. No. 371

1 copy

RECEIVED Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada — AUG 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 006
d. FULL NAME OF HOSPITAL OR INSTITUTION Boise Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3115 Sycamore

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	Alma	Morrow	July 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	May 10, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Cheyenne, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Otto G. Reinhardt Guttenberg, Ia		Matilda Peterson	Kolmar, Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	519-20=3670D	Jack O. Morrow	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 da

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Res. C.V.D. — 7 yrs
DUE TO (c) Cerebral Arteriosclerosis — ? i

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mal-nutrition - mental deterioration — 6 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug - 9, 1958, to July 28, 19 69, that I last saw the deceased alive on July 28, 1969, and that death occurred at 8:55a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl B. Smithson M.D.	Boise Idaho	7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/31/1969	Challis Cemetery	Challis, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5, 1969	Myrtle Palmer	Grant Waggoner	E-422

FIRM NAME: Alden Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG - 5 1969

SEP 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 8 1969 Bureau of Vital Statistics

State File No. 3057
Local Reg. No. 508
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY ADA 011 102	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE; c. LENGTH OF STAY (In this place) TWO YEARS	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BOISE CONVALSCENT CENTER 332	d. STREET ADDRESS (If rural, give location) 808 No. CURTIS

3. NAME OF DECEASED (Type or Print) a. (First) LOUISE b. (Middle) INEZ c. (Last) STUDLEY				4. DATE OF DEATH (Month) (Day) (Year) JULY 28, 1969	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	8. DATE OF BIRTH JULY 23, 1893	9. AGE (In years last birthday) 76	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 01	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LINN COUNTY, OREGON	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME WILLIAM BARCUS	BIRTHPLACE UNITED STATES		14. MOTHER'S MAIDEN NAME MILLIGAN,	BIRTHPLACE UNITED STATES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 2 (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 519 66 4479		17. INFORMANT'S OWN SIGNATURE x Phyllis E. Studley	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Esterio Sclerotic Cardio Vascular disease — 15 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 357 (Degree or title) MS	23b. ADDRESS Boise Ida	23c. DATE SIGNED 7-31-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 3	24b. DATE JULY 31, 1969	24c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery near Shedds, Oregon	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. Aug. 5 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Conway Grant	LICENSE NO. E478

FIRM NAME: RALYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3058
Local Reg. No. 491
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2930 Sheffield Ct.

3. NAME OF DECEASED (Type or Print)
a. (First): Arthur
b. (Middle): H
c. (Last): Jones

4. DATE OF DEATH (Month) (Day) (Year): July 29, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 10-31-27
9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bld'g. Materials 06
10b. KIND OF BUSINESS OR INDUSTRY: Boise Cascade
11. BIRTHPLACE (State or foreign country): Portland, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis D. Jones — BIRTHPLACE: Ill.
14. MOTHER'S MAIDEN NAME: unk. McCabe — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): WW # 2 4
16. SOCIAL SECURITY NO.: 543-22-9340
17. INFORMANT'S OWN SIGNATURE: Heather M. Jones — ADDRESS: 2930 Sheffield Ct.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

209X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Agnogenic Myeloid Metaplasia — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 67, *to* 7-29, 19 69, *that I last saw the deceased alive on* 7-29-69, 19____, *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 1730 [signature] MD
23b. ADDRESS: 425 Bannock Bain
23c. DATE SIGNED: 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 7/31/69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-1-69
REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson
25. EMBALMER: [signature] — LICENSE NO.: E-527
FIRM NAME: Mountain View Funeral Home, Boise

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 31 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. SEP 22 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25. NOV 16 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to JAN 11 1971

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided~~ In the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3059
Local Reg. No. 502
Reg. Dist. No. 370

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 01 — AUG - 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Boise
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Horizon Drive 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3509 Windsor Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Vincent	John	Aguirre	July	30	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Oct. 20, 1920	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Partner Royal Restaurant
10b. KIND OF BUSINESS OR INDUSTRY: same
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Aguirre — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Gabirra Goitia — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT'S OWN SIGNATURE: Mercilla Aguirre — ADDRESS: Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed, Mangled, & Burned Body — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Air Plane Collision in Air. — Brief.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 920A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 [signature]	Coroner	3720 Meadow Drive, Boise.	8-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 4, 1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 4 1969	Myrtle Palmer	Gary A. Sawyer	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

AUG - 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 6 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 12 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 18 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

SEP 10 1969

(a) Knowingly supply false information to any one connected with completing a death certificate.
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

OCT 1 1974

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

NOV 26 1975

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3060
Local Reg. No. 499
Reg. Dist. No. 370

RECEIVED
AUG - 4 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 500 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Boise 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3321 North Cole Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
BASIL	PHILIP WARTERLOW	CLAPIN	July	30	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Jan. 30, 1918	51		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pilot 10	Boise Aviation	Tonbridge Kent England	England

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
A. C. Clapin	England		England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	519-48-2237	Lorna Clapin	3321 N. Cole Road Boise, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8414

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed, & Mangled Body. — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Air Plane Collision in Air. — Brief
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *19__, to 19__, that I last saw the deceased alive on __, 19__, and that death occurred at* 920A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 E. J. Davis	Coroner	3720 Meadow Drive, Boise	8-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 4, '69	Dry Creek Cemetery	Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 4 1969	Myrtle Palmer	Gary A. Cooper	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 8 1969
APR 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3061
Local Reg. No. 493
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 01 500
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION North Boise 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Oregon 38 b. COUNTY Union 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) LaGrande
d. STREET ADDRESS (If rural, give location) Route #2 South 12th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
FRANK	KENNETH	FLANERY	July	30	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Aug. 15, 1920	48		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wholesale 26	Poultry	LaGrande, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Flanery, Union City;	Oregon	Bertha Van Orsdole	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No 2	0	541-10-5136	Personal Records Summers Funeral Home - Robert G. Ross

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8414

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed, Mangled, & Burned Body. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Air Plane Collision in Air. — Brief.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes X No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 920A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 C. L. Sams	Coroner 4	3720 Meadow Dr; Boise,	8-I-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	July 31, 1969	Summerville	Summerville Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1 1969	Myrtle Palmer	Gary A. Cowger	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG - 1 1969

SEP 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 9 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3062
Local Reg. No. 536
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 20 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE R...
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: ST. LUKE'S HOSPITAL 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1615 BLUFF

3. NAME OF DECEASED (Type or Print): a. (First) CARL b. (Middle) F c. (Last) JOHNS

4. DATE OF DEATH: (Month) (Day) (Year) JULY 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	Married 3	Jan. 19, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Motels and Apartments 22	OWNER	Milan, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin Franklin Johns	Ohio	Lena Ross	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No. 2	------0------	519-40-2072-A	X Mrs C F Johns	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Emphysema

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Stewart Merrill 357	MD	Boise Ada	8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-1-1969	Morris Hill Cemetary	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 15, 1969	Myrtle Palmer	Conway Grant	E-478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 6 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3063
Local Reg. No. 302
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 01 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Horizon Drive 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1821 Edgecliff Terrace

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ray	Maurice	Kingland	July	30	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 16, 1920	49				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Doctor 14	Doctor	Forrest City, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Levi Kingland	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	8414	Jack C. Branden	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed, Mangled, & Burned Body — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Air Plane Collision in Air. — Brief.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 920A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 [illegible]	Coroner 4	3720 Meadow Drive, Boise.	8-I-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 2, 1969	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 4, 1969	Myrtle Palmer	Ray C. Summers	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 15 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3064
Local Reg. No. 494
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada 500
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Boise 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Oregon 38 b. COUNTY Clackamas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Milwaukie 555
d. STREET ADDRESS (If rural, give location) 15032 S. E. Del Ray Dr.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DONALD	JOHN	RUZICKA	July	30	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Oct. 21, 1926	42		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
26 Dist. Sales Manager	Package Corp.	Burchard, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Ruzicka	Czechoslovakia	Lottie Flider	Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE AND ADDRESS
Yes	W. W. II 4	506-24-9158	Personal Records Summers Funeral Home Gary G. Summers

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8414

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed, Mangled, & Burned Body. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Air Plane Collision in Air, — Brief.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 920 A.m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 C. W. Paris	Coroner 4	3720 Meadow Dr; Boise.	8-I-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	July 30, 1969	Milwaukie	Milwaukie Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1 1969	Myrtle Palmer	Robert G. Summers	E-497

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG - 1 1969
OCT 17 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED AUG - 4 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3065
Local Reg. No. 500
Reg. Dist. No. 370
BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 500
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION North Boise 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 7105 Brookover Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EUGENE	C.	SMITH	July 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Dec. 20, 1924	44		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attorney 16		Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
E. B. Smith	Boise, Idaho	Pearl Morgan	Moscow, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes / W.W. #2 4	519-16-6063	Mrs. Louise C. Smith	7105 Brookover Dr. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8414

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Crushed, & Mangled Body.	Inst;
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Air plane collision in Air.	Brief.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident /		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Did Not See Alive, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at 920 A m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 E. D. Paris	Coroner	3720 Meadow Dr; Boise,	8-I-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial /	8-2-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 4 1969	Myrtle Palmer	Gary A. Colgan	E-526

FIRM NAME: SUMMERS FUNERAL HOME, INC.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG - 4 1969

SEP 10 1969

SEP 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3066
Local Reg. No. 538
Reg. Dist. No. 270

BIRTH NO.

AUG 22 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 01 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1218 North 24th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	FRANKLIN	MURPHY	July 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed 2	June 1, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lineman-Repairman 09	Idaho Power Co.	Ireland	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
------	Ireland	---------	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	518-09-4629	Mrs. Viana M. Jones	1700 State Hemet, Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, to _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:25 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
039 Mary L. Bell, MD	Boise, Idaho	8/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-7-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 20, 1969	Myrtle Palmer	Robert G. Ross	E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 5 1969

JUN 1 9 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3067
Local Reg. No. 505
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Accident Franklin and Roosevelt 0001

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 2906 Inglewood

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SPENCER	LAWSON	WARD	JULY 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	NEVER MARRIED	Nov. 3, 1947	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Student College 03	Student	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
C. Raymond Ward	Blackfoot, Idaho	Myra C. Lawson	Pocatello, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	----------	519-54-6183	x C. Raymond Ward	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8120

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Compound Fracture of Skull & Laceration of the Brain. — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		Lost Control of his Auto, Hit large Road Machine.

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 110 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 E. L. Paris	Coroner 4	3720 Meadow Drive, Boise.	8-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	8-4-1969	Cloverdale Cemetery	Boise Ada	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5, 1969	Myrtle Palmer	Gary L. Cowger	E-526

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG - 5 1969
SEP 8 - 1969
MAR 4 1970
MAY 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3068
Local Reg. No. 12
Reg. Dist. No. 300

RECEIVED JUL 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
LENGTH OF STAY (In this place): 006
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 108 Michigan 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
d. STREET ADDRESS (If rural, give location): 108 Michigan

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Victor	Manuel	Oling	July	9	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	August 6, 1891	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Vasa, Finland	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Manuel M. Oling	Finland	Louisa Betty Nybuck	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	4109	519-10-3399	Manilas Oling	Council, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 12:20 PM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold Whitney Adams County Coroner	Council, Idaho	7-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 12, 1969	I.O.F. Cemetery	Council, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-21-69		K. Dan Thomason	E-388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3069
Local Reg. No. 11
Reg. Dist. No. 300

Certificate of Death

RECEIVED STATE OF IDAHO

JUL 23 1969

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 020 Adams 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Near Council
c. LENGTH OF (If not in this place) hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Starkey Swimming Pool 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Lakeshore Drive

3. NAME OF DECEASED (Type or Print)
a. (First) STEFAN
b. (Middle)
c. (Last) POLLARD

4. DATE OF DEATH (Month) (Day) (Year) July 10, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 1
8. DATE OF BIRTH Apr. 19, 1955
9. AGE (In years last birthday) 14 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Dieburg, Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James W. Pollard — BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Alice L. Vanderkolk — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 3 — (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE X James W. Pollard — ADDRESS Nampa, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Starkey Pool 18
21c. (CITY, TOWN, OR TOWNSHIP) 13 — (COUNTY) 020 Adams — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 10 1969 3:59PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 3:59P m., from the causes and on the date stated above.*

23a. SIGNATURE Harold Whitley 483 — (Degree or title) Adams County Coroner 4
23b. ADDRESS P.O. Box 215 Council Idaho
23c. DATE SIGNED 7-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 7/15/69
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Gardens
24d. LOCATION (City, town, or county) (State) Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG. 7-21-69
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Richard W. Mesenbrink — LICENSE NO. E-487

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 26 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3070
Local Reg. No. 242
Reg. Dist. No. 510

RECEIVED JUL 28 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 430 North Third Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Linette
b. (Middle): Marie
c. (Last): Jackson

4. DATE OF DEATH (Month) (Day) (Year): July 2 1969

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: June 13, 1969
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 19 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ***** 00
10b. KIND OF BUSINESS OR INDUSTRY: *****
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Sidney J. Jackson — BIRTHPLACE: Phoenix, Arizona
14. MOTHER'S MAIDEN NAME: Mary Cotton — BIRTHPLACE: Clarksville, Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): ***** 0
16. SOCIAL SECURITY NO.: *****
17. INFORMANT'S OWN SIGNATURE: Mary L. Cotton — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3209

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute purulent meningitis — INTERVAL BETWEEN ONSET AND DEATH: ~24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 13, 1969, *to* July 2, 1969, *that I last saw the deceased alive on* July 2, 1969, *and that death occurred at* 10:28 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Sydney J. Horrocks, MD
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: July 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: JUL 25 1969
REGISTRAR'S SIGNATURE: Gloria Dopetta
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3071
Local Reg. No. 230
Reg. Dist. No. 511

BIRTH NO.

RECEIVED JUL 17 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 08

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rockland
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) BERT; b. (Middle) ALBERT; c. (Last) NELSON

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1969

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 24, 1892

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months 10 Days 8
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Paradise, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Peter Nelson
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Anne Sabina Christensen
BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-40-4478

17. INFORMANT'S OWN SIGNATURE: x May Nelson
ADDRESS: Rockland, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic pulmonary emphysema — 10 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* March 6, 1969, *to* July 2, 1969, *that I last saw the deceased alive on* July 2, 1969, *and that death occurred at* 2:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. H. Anderson, M. D.
23b. ADDRESS: 1448 E. Center Pocatello, Ida.
23c. DATE SIGNED: Jul. 9, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial
24b. DATE: 7-5-69
24c. NAME OF CEMETERY OR CREMATORY: Valley View Cemetery
24d. LOCATION (City, town, or county) (State): Rockland, Idaho

DATE REC'D BY LOCAL REG.: JUL 15 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: H. L. Davis
LICENSE NO.: E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3072
Local Reg. No. 227
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bannock 031

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello

c. LENGTH OF STAY (In this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 536 East Hayden Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bannock 031

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello

d. STREET ADDRESS (If rural, give location): 536 East Hayden Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
TOM		MURRAY	July	3	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Divorced 4	Mar. 13, 1911	58				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 07	General Contracting	Huntsville, Texas	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Murray	Texas	Margaret	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
3 Unknown 0	466-07-8886	Personal Records	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease 4123

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 day, 19 67, *to* July 3, 19 69, *that I last saw the deceased alive on* July 3, 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Pocatello, Idaho	July 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 11, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 11 1969	Gloria Dopita	[signature]	E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3073
Local Reg. No. 239
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Bannock 03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1553 East Fremont

3. NAME OF DECEASED (Type or Print) a. (First) ANNIE b. (Middle) ELIZABETH c. (Last) JENSEN

4. DATE OF DEATH (Month) (Day) (Year) July 4, 1969

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Aug. 7, 1883

9. AGE (In years last birthday) 85
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) St. Charles, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William S. Blackburn
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Hannah Anderson
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) XXXXX

16. SOCIAL SECURITY NO. 4723

17. INFORMANT'S OWN SIGNATURE Stella J. Wright
ADDRESS Pocatello

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease
INTERVAL BETWEEN ONSET AND DEATH Nov. 1966

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 1969, to July 4, 1969, that I last saw the deceased alive on July 4, 1969, and that death occurred at 6:10p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [signature] MD

23b. ADDRESS 1448 E. Center, Pocatello, Ida.

23c. DATE SIGNED 7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jul.7,1969

24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery

24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. JUL 22 1969

REGISTRAR'S SIGNATURE Gloria Dopita

25. EMBALMER Theron Miller

LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUL 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

AUG 12 1969

Bureau of Vital Statistics

State File No. 3074
Local Reg. No. 243
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY: Bannock 031

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello

c. LENGTH OF STAY (In this place): 100 years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Bannock 031

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello

d. STREET ADDRESS (If rural, give location): 212 West Alameda Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MORLAN	MELTIAR	FAIRCHILD	July 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Oct. 16, 1881	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Oakley Basin, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Moroni Joshua Fairchild	Utah	Amy Jesse Hatch	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	0			

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic heart disease with atrial fibrillation, cardiomegaly, and congestive heart failure — many years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
No		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 8, 19 68 *to* July 5, 19 69, *that I last saw the deceased alive on* March 28, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J E Comstock MD	Box 852-Pocatello-Idaho	7-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Jul. 8, 1969	Grove City Cemetery	Blackfoot, Bingham, Idaho	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 11 1969	Gloria Dopita		E-234

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 12 1969

MAR 16 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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State File No. 3075
Local Reg. No. 225
Reg. Dist. No. 510

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 031 JUL 1 1 1969
a. COUNTY Bannock 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Comm. Hospit. 019

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 3847 Pole Line Road

3. NAME OF DECEASED (Type or Print)
a. (First) RUTH
b. (Middle)
c. (Last) MC NEAL

4. DATE OF DEATH (Month) July (Day) 5 (Year) 1969

5. SEX Remale
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 15, 1920
9. AGE (In years last birthday) 48 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary 19
10b. KIND OF BUSINESS OR INDUSTRY Law
11. BIRTHPLACE (State or foreign country) Dubois, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Carl Schindler BIRTHPLACE Nebraska
14. MOTHER'S MAIDEN NAME Matilda Theissen BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5718 cirrhosis of Liver & acute Liver Failure — INTERVAL BETWEEN ONSET AND DEATH 2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-30-69, 19__, *to* 7-5-, 19 69, *that I last saw the deceased alive on* 7-5-, 19 69, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 3+2 David E. Miller, M.D.
23b. ADDRESS Pocatello Idaho
23c. DATE SIGNED 7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9 July 1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) Pocatello (State) Idaho

DATE REC'D BY LOCAL REG. JUL 1 6 1969
REGISTRAR'S SIGNATURE Glorie Dopita
25. EMBALMER George W. Knoth
LICENSE NO. 409

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 16 1974

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3076
Local Reg. No. 258
Reg. Dist. No. 511

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCammon
c. LENGTH OF STAY (In this place): -- 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence Box 63 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCammon SPOUSE: H.Eugene Dalton
d. STREET ADDRESS (If rural, give location): Box 63

3. NAME OF DECEASED (Type or Print)
a. (First): MARY ELLEN
b. (Middle): McKAY RICHARDSON
c. (Last): DALTON

4. DATE OF DEATH (Month) (Day) (Year): July 6 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Dec. 23, 1890
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Malad City, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH McKAY — BIRTHPLACE: U.S.A. Aboard ship
14. MOTHER'S MAIDEN NAME: ANNIE JENKINS — BIRTHPLACE: WALES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO 3 — (If yes, give war or dates of service): -- 0
16. SOCIAL SECURITY NO.: 519-56-4251
17. INFORMANT'S OWN SIGNATURE: Eugene Dalton — ADDRESS: McCammon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1739

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer of Skin over sacrum — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Anemia
DUE TO (c): Severe Past radiation cystitis c̄ Hemorrhage

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1955, *to* 7-3, 1969, *that I last saw the deceased alive on* 3-28, 1969, *and that death occurred at* 7:30a. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 079 M.D.
23b. ADDRESS: Downey, Idaho
23c. DATE SIGNED: July 8,1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: July 9,1969
24c. NAME OF CEMETERY OR CREMATORY: Malad City Cemetery
24d. LOCATION (City, town, or county) (State): Malad City, Oneida, Idaho

DATE REC'D BY LOCAL REG.: 8-5-69
REGISTRAR'S SIGNATURE: Ila Mae Cunningham
25. EMBALMER: Ranford G. Benson
LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 24 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3077
Local Reg. No. 531
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
JUL 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 112 Lou Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WALTER	BEAUREGARD	HARRIS	July 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married 3	Sept. 16, 1902	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
10 Union Pacific Railroad		Gaffney, S. Carolina	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Westley Harris		Nancy Elizabeth Gorden	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	XXXX 0		Lydia Harris	112 Lou Ave

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

402X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hypertension Ward disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 2, 1956, *to* 7 July, 1969, *that I last saw the deceased alive on* 7 July, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Pocatello Idaho	7-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 10, 1969	Restlawn Memorial Gardens,	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 14 1969	Florence Dopita	Theron Miller	E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 17 1969
AUG 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3078
Local Reg. No. 232
Reg. Dist. No. 510

BIRTH NO.

JUL 23 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location) 713 South Hayes

3. NAME OF DECEASED (Type or Print) a. (First) NINA	b. (Middle) JUNE	c. (Last) STEWART	4. DATE OF DEATH (Month) (Day) (Year) July 8, 1969	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4	8. DATE OF BIRTH 3 April 1910	9. AGE (In years last birthday) 59 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Landing, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence R. Stewart	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Emma Mae Kirby	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX No 2 (If yes, give war or dates of service) xxxx 0	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Mrs. Ernest Jackson	ADDRESS Pocatello	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2051

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic myelocytic leukemia — INTERVAL BETWEEN ONSET AND DEATH several yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Cor pulmonale and myocarditis
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 19, 1952, *to* July 8, 1969, *that I last saw the deceased alive on* July 8, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) L S Call MD	23b. ADDRESS Box 852-Pocatello, Idaho	23c. DATE SIGNED 7-14-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11 July 1969	24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery	24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Theron Miller	LICENSE NO. E-524

JUL 12 1969

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3079
Local Reg. No. 243
Reg. Dist. No. 510

BIRTH NO.

RECEIVED Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: 031 Bannock — JUL 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 406 South Seventh Avenue

3. NAME OF DECEASED (Type or Print): a. (First) EDITH — b. (Middle) A. — c. (Last) CHASE

4. DATE OF DEATH (Month) (Day) (Year): July 10, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 13, 1885

9. AGE (In years last birthday): 83
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Agate, Colorado

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Egger — BIRTHPLACE: Austria

14. MOTHER'S MAIDEN NAME: Teresa Shosen — BIRTHPLACE: Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): XXXX 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Jesse T. Chase

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): General Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) Pocatello (COUNTY) (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 7 69, 1961, *to* July 10, 19 69, *that I last saw the deceased alive on* July 7, 19 69 *and that death occurred at* [illegible] m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): 348 R. D. Hoeppner M.D. — **23b. ADDRESS**: Pocatello — **23c. DATE SIGNED**: 7-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: July 12, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Mountainview Cemetery — **24d. LOCATION** (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: JUL 24 1969

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Theron Miller — LICENSE NO.: E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 2 8 1969

MAY 1 6 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 2 6 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3080
Local Reg. No. 233
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Eldredge Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 124 East Bryan Road

3. NAME OF DECEASED (Type or Print) a. (First) ERNEST (EARNEST) b. (Middle) LEO c. (Last) SHURTLIFF

4. DATE OF DEATH (Month) July (Day) 11, (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Sept. 19, 1897

9. AGE (In years last birthday) 71
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 26 Warehouse Supervisor

10b. KIND OF BUSINESS OR INDUSTRY Naval Ord. Plant

11. BIRTHPLACE (State or foreign country) Ucon, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Luman E. Shurtliff
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Harriet L. Strong
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 3

16. SOCIAL SECURITY NO. 4109

17. INFORMANT'S OWN SIGNATURE Melvin J. Oregon
ADDRESS California

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from — , 19 , to — , 19 , that I last saw the deceased alive on 7-11-69 , 19 , and that death occurred at 1:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE Burton H. Sim 583 (Degree or title) Coroner

23b. ADDRESS Bannock Co. Ida.

23c. DATE SIGNED 7-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jul. 15, 1969

24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery

24d. LOCATION (City, town, or county) Pocatello, Bannock, (State) Idaho

DATE REC'D BY LOCAL REG. JUL 17 1969

REGISTRAR'S SIGNATURE Gloria Dopita

25. EMBALMER Theron Miller

LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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69-6607

BIRTH NO.

Certificate of Death
STATE OF IDAHO

State File No. 3081
Local Reg. No. 250
Reg. Dist. No. 510

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 865 El Rancho

3. NAME OF DECEASED (Type or Print)
a. (First) CLIFFORD
b. (Middle) DANIEL
c. (Last) SYKES

4. DATE OF DEATH (Month) (Day) (Year) July 12, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 1
8. DATE OF BIRTH July 9, 1969
9. AGE (In years last birthday) IF UNDER 1 YR. Months Days 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02
10b. KIND OF BUSINESS OR INDUSTRY XXXXX
11. BIRTHPLACE (State or foreign country) Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Mason Sykes BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Rita Maxine Burwell BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) XXXX 0
16. SOCIAL SECURITY NO. XXXX
17. INFORMANT'S OWN SIGNATURE Robert M Sykes ADDRESS

18. CAUSE OF DEATH 7761
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hyaline membrane

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth *, 19__, to* July 12 *, 19*69*, that I last saw the deceased alive on* July 12 *19*69*, and that death occurred at* 6p *m., from the causes and on the date stated above.*

23a. SIGNATURE 671 Roger W Boe MD (Degree or title)
23b. ADDRESS 527 S. 12
23c. DATE SIGNED 7/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE July 14, 1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. AUG 11 1969
REGISTRAR'S SIGNATURE Gloria Dopeta
25. EMBALMER Theron S Miller
LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 22 1969 Bureau of Vital Statistics

State File No. 3082
Local Reg. No. 263
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY 031 Bannock b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello LENGTH OF STAY (In this place) 008 d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Anthony Hospital 019	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello d. STREET ADDRESS (If rural, give location) 1111 Wilson

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	Emily	Bailey	July 13 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years, last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	Dec. 27, 1887	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	own home	Finland	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Lofgren	Finland	Emily	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	XXX 0			

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5320

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Adenomatous polyp stomach and chronic duodenal ulcer with hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-8-69	As above	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-5-69, 19__, *to* 7-13-69, 19__, *that I last saw the deceased alive on* 7-13, 1969, *and that death occurred at* 11:22 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. M. Graves, MD	1448 East Center Pocatello, Idaho	8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 16, 1969	Restlawn	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 18 1969	Dlona Dopsta	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

AUG 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3083
Local Reg. No. 234
Reg. Dist. No. 5-10

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Nursing Home 399

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello 031
d. STREET ADDRESS (If rural, give location) 303 North Hayes Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	RUTH	J.	GALBRAITH	July	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	March 21, 1885	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Ontario, Canada
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William G. Carson — BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Elizabeth Middleton — BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2
(If yes, give war or dates of service) ****** 0
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

0539

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition — INTERVAL BETWEEN ONSET AND DEATH: app 3 mnths

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Protracted post-herpetic zoster pain — app 3 mons
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS 1) Remote myocardial infarction
Conditions contributing to the death but not related to the disease or condition causing death. 2) Recent fracture radius

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1959, *to* July 13, 1969, *that I last saw the deceased alive on* July 19, 1969, *and that death occurred at* 2:40a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J E Comstock MD	Pocatello, Idaho	July 15, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 16, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 10 1969	Gloria Dopita		E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

State File No. 3084
Local Reg. No. 271
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (In this place) 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Nursing Hom e 206 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Jackson b. (Middle) c. (Last) Mobe
4. DATE OF DEATH (Month) (Day) (Year) July 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Am. Indian	Never Married /	about 1889	about 80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Laborer 04	Agriculture	Lemhi, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Mobe	Lemhi, Idaho	Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	None	Lucy George	Fort Hall, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pyelonephritis Obstructive Uropathy.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June, 1969, to July 14, 1969, that I last saw the deceased alive on July 14, 1969, and that death occurred at 11:45p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. Wixom M.D.	Pocatello, Idaho	July 17, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 17, 1969	Gibson Mission Cemetery	Bingham County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 22 1969	Gloria Dopita	E. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 3085
Local Reg. No. 240
Reg. Dist. No. 211

BIRTH NO.

1. PLACE OF DEATH 030 JUL 23 1969
a. COUNTY Bannock

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Butte 120

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics
Pocatello -rural

c. LENGTH OF STAY (In this place) 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Atomic City

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South of City 000

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JAMES b. (Middle) RAYMOND c. (Last) IRETON

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4

8. DATE OF BIRTH Sept.23,1940

9. AGE (In years last birthday) 28 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nuclear Physicist 08

10b. KIND OF BUSINESS OR INDUSTRY Arco Reactor Site

11. BIRTHPLACE (State or foreign country) Kansas City, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Ireton BIRTHPLACE

14. MOTHER'S MAIDEN NAME Marie BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1 (If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE James F. Ireton ADDRESS

18. CAUSE OF DEATH 8169
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Basal Fracture, Skull

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Internal Injuries

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident 1

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) County Road 06

21c. (CITY, TOWN, OR TOWNSHIP) 030 (COUNTY) (STATE) B Bannock, Idaho.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-15-69 10 55 p m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Car out of Control.

22. *I hereby certify that I attended the deceased from* — *19*____, *to* — *19*____, *that I ~~last~~ saw the deceased ~~alive~~ dead on* 7-15-69 *19*____, *and that death occurred at* 10 55 p *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton John 583 (Degree or title) Coroner 4

23b. ADDRESS Bannock Co. Ida.

23c. DATE SIGNED 7-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE Jul.17,1969

24c. NAME OF CEMETERY OR CREMATORY Naylor& Quinn Mort.

24d. LOCATION (City, town, or county) (State) Pittsburg, Kansas

DATE REC'D BY LOCAL REG. JUL 22 1969 JUL 2 - 1969

REGISTRAR'S SIGNATURE Gloria Doneta

25. EMBALMER Theron Miller

LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 4 1969
JUL 2 9 1969
AUG 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3086
Local Reg. No. 235
Reg. Dist. No. 510

Certificate of Death

RECEIVED
JUL 23 1969
Bureau of Vital

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Comm. Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 461 Pershing St.

3. NAME OF DECEASED (Type or Print)
a. (First): OLIS
b. (Middle):
c. (Last): JONES

4. DATE OF DEATH (Month) (Day) (Year): July 15, 1969

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 5, 1914
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance 10
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Cameron, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Matt Jones — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Rose (Unk) — BIRTHPLACE: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 451-12-3264
17. INFORMANT'S OWN SIGNATURE: Mrs Darlene Jones — ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Ca of Lung —
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1969, *to* 7-15, 1969, *that I last saw the deceased alive on* 7-15, 1969, *and that death occurred at* 11A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 362 David C. Miller, MD-1
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 7-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Jul 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mission Cemetery
24d. LOCATION (City, town, or county) (State): Fort Hall Idaho

DATE REC'D BY LOCAL REG.: JUL 18 1969
REGISTRAR'S SIGNATURE: Gloria Dopeta
25. EMBALMER: George W. Knoff — LICENSE NO. 409
FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 2 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3087
Local Reg. No. 236
Reg. Dist. No. 510

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write township): Pocatello
LENGTH OF STAY (in this place): 100 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 346 E. Griffith Rd. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 346 E. Griffith Rd.

3. NAME OF DECEASED (Type or Print)
a. (First): GRACE
b. (Middle): GRAY
c. (Last): MILLER

4. DATE OF DEATH: (Month) July (Day) 15 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 25, 1877

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Nodoway County, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles F. Gray
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Mary Ann McLaughlin
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 519-54-1848

17. INFORMANT'S OWN SIGNATURE: Margaret Miller
ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease 4123
INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 7-15, 1969, *that I last saw the deceased alive on* 7-15, 1969, *and that death occurred at* 1:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 362 Howard C. Miller

23b. ADDRESS: Pocatello Idaho

23c. DATE SIGNED: 7-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jul 18, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REGISTRAR: JUL 18 1969

REGISTRAR'S SIGNATURE: Elona Dopita

25. EMBALMER: George A. Knoll
LICENSE NO.: 409
FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 2 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 3 0 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3088
Local Reg. No. 256
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello c. LENGTH OF STAY (in this place): 000	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 014	d. STREET ADDRESS (If rural, give location): 735 East Hayden Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CHESTER	ALMO	THOMPSON	July	15	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	December 22, 1914	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Conductor 10	Union Pacific R.R.	Sublette Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Bain Thompson	Centerville, Iowa	Maude Tipton	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes 1	World War II 4	543-10-3535	Virginia Thompson	Pocatello, Idaho

4309

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sddy

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 13 July, 1969, *to* July 15, 1969, *that I last saw the deceased alive on* July 15, 1969, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
113 [signature] MD	Pocatello, Idaho	July 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	July 17, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 23 1969	Gloria Dopita	Jack Henderson	E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 3 0 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 9 1981

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3089
Local Reg. No. 245
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG - 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Nursing Home 299

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Bannock Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First): ELIAS
b. (Middle):
c. (Last): HUNLEY

4. DATE OF DEATH (Month) (Day) (Year): July 17 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 23, 1886
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer 21
10b. KIND OF BUSINESS OR INDUSTRY: Municpal & Corp.
11. BIRTHPLACE (State or foreign country): Terre Haute Indiana
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME / BIRTHPLACE: John B. Hunley
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Mary Bannister Vaselake

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 518-14-1120
17. INFORMANT'S OWN SIGNATURE: Mrs Lloyd Nelson — ADDRESS: Pocatello, Idaho

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello Bannock Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1958, *19*__, *to* July 17, *19* 69, *that I last saw the deceased alive on* July 17, *19* 69, *and that death occurred at* 8:30 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 248 S. Bannock Ave
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: July 22, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: JUL 28 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 3 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 22 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3090
Local Reg. No. 241
Reg. Dist. No. 510

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 28 1969

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN: Pocatello
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 608 So. 10th

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): G.
c. (Last): ZWEIGART

4. DATE OF DEATH (Month) (Day) (Year): July 18, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 8, 1886

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher 21

10b. KIND OF BUSINESS OR INDUSTRY: Meat Processing

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Zweigart
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Pauline
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-09-9823

17. INFORMANT'S OWN SIGNATURE: Juanita Zweigart
ADDRESS: Pocatello, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Left lower lobe pneumonia
INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Chronic congestive heart failure.
INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO (c): Uremia
INTERVAL BETWEEN ONSET AND DEATH: Months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Fracture, neck, rt. femur.
INTERVAL BETWEEN ONSET AND DEATH: Days

8808

19a. DATE OF OPERATION: July 15, 1969

19b. MAJOR FINDINGS OF OPERATION: Fracture, neck, rt. femur

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello 13 Bannock 03 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 15 1969 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Fell off step

22. *I hereby certify that I attended the deceased from* Jan. 11, 1964, *to* July 18, 1969, *that I last saw the deceased alive on* July 18, 1969, *and that death occurred at* 3:40 pm, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): ARCH WIGLE, M.D.

23b. ADDRESS: 1605 No. Arthur Pocatello, Idaho 83201

23c. DATE SIGNED: July 23, '69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 22-69

24c. NAME OF CEMETERY OR CREMATORY: Mountainview

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: JUL 28 1969

REGISTRAR'S SIGNATURE: Gloria Downard

25. EMBALMER: John P. Downard

LICENSE NO.: E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 30 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 12 1969

State File No. 3091
Local Reg. No. 251
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello	c. LENGTH OF STAY (In this place): 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019	d. STREET ADDRESS (If rural, give location): 515 East Lander

3. NAME OF DECEASED (Type or Print)	a. (First): DORIS	b. (Middle):	c. (Last): STEWART	4. DATE OF DEATH (Month) (Day) (Year): July 19, 1969
5. SEX: Female	6. COLOR OR RACE: Indian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: Nov. 11,1926	9. AGE (In years last birthday): 42 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Owyhee, Nevada	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Jim Humpey	BIRTHPLACE: Owyhee, Nevada	14. MOTHER'S MAIDEN NAME: Bessie McKinney	BIRTHPLACE: Owyhee, Nevada	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2	(If yes, give war or dates of service): XXX 0	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: [signature]	ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

570X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute & chronic hepatitis, cirrhosis & terminal liver failure — INTERVAL BETWEEN ONSET AND DEATH: weeks

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18-69, 19__, *to* 7-19-, 19 69, *that I last saw the deceased alive on* 7-19-69, 19__, *and that death occurred at* 3 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 362 DC Miller	(Degree or title): MD	23b. ADDRESS: Pocatello Idaho	23c. DATE SIGNED: 7-24-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: Jul.23,1969	24c. NAME OF CEMETERY OR CREMATORY: Cedars Cemetery	24d. LOCATION (City, town, or county) (State): Fort Hall, Idaho
DATE REC'D BY LOCAL REG.: AUG 11 1969	REGISTRAR'S SIGNATURE: Gloria Dopeta	25. EMBALMER: Theron Miller	LICENSE NO.: E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 12 1969

State File No. 3092
Local Reg. No. 252
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello Bureau	c. LENGTH OF STAY (In this place) 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location) 906 South Second Avenue

3. NAME OF DECEASED (Type or Print)	a. (First) GORDON	b. (Middle) A.	c. (Last) WILSON	4. DATE OF DEATH (Month) (Day) (Year) July 19, 1969
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3	8. DATE OF BIRTH May 23,1906	9. AGE (In years last birthday) 63 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21	10b. KIND OF BUSINESS OR INDUSTRY Carpentry	11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Allen Wilson	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Jennie	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1 (If yes, give war or dates of service) 8	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Nellie M Wilson	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction probable — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 July, 1969, *to* 19 July, 1969, *that I last saw the deceased alive on* 19 July, 1969, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23a. SIGNATURE 1131 Randall	(Degree or title) MD	23b. ADDRESS Pocatello Ida	23c. DATE SIGNED 8-5-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE Jul.23,1969	24c. NAME OF CEMETERY OR CREMATORY Restlawn Mem.Gardens	24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho
DATE REC'D BY LOCAL REG. AUG 11 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Theron Miller	LICENSE NO. E-524

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 2 1969

AUG 1 0 1976

AUG 2 6 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3093
Local Reg. No. 242
Reg. Dist. No. 5-11

BIRTH NO. 69-2169

RECEIVED AUG - 5 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Pocatello
c. LENGTH OF STAY (in this place): 1 day 00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rio Vista Road

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Pocatello
d. STREET ADDRESS (If rural, give location): Rio Vista Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ANTOINETTE	SONYA	BALLARD	July 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Indian	Never Married	Mar. 25, 1969		3	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	- -	Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wilford Ballard Sr.	Idaho	Leota Ponzo	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	None	Leota Ballard	Rt.1 No.Pocatello Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden unexpected (cred) death 7969

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) undetermined
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/27, 1969, *to* 3/30, 1969, *that I last saw the deceased alive on* 3/30, 1969, *and that death occurred at* 2 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Kullard MD	527 S 12 Pocatello, Idaho	7/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jul.25-69	Cedars Cem.	Bannock County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 31 1969	Gloria Dopita	John P. Downard	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3094
Local Reg. No. 264
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 030 AUG 22 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey
c. LENGTH OF STAY (in this place) 2 mo. 302
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Marsh Valley Hospital 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Franklin 21
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 147 West Oneida

3. NAME OF DECEASED (Type or Print) a. (First) Lorenzo b. (Middle) Erastus c. (Last) Hansen

4. DATE OF DEATH (Month) (Day) (Year) July 24 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 9, 1879

9. AGE (In years last birthday) 90 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24

10b. KIND OF BUSINESS OR INDUSTRY Lumber Yard

11. BIRTHPLACE (State or foreign country) Plain City, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Praben A. Hansen BIRTHPLACE Copenhagen, Denmark

14. MOTHER'S MAIDEN NAME Emma Peterson BIRTHPLACE Lehi, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO. 519 03 2771

17. INFORMANT'S OWN SIGNATURE Catherine B. Hansen ADDRESS Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis

DUE TO (c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4123

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1965 to July, 1969, that I last saw the deceased alive on July 24, 1969, and that death occurred at 4:55 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [signature]

23b. ADDRESS Preston Idaho

23c. DATE SIGNED 8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 28, 1969

24c. NAME OF CEMETERY OR CREMATORY Preston

24d. LOCATION (City, town, or county) Preston (State) Idaho

DATE REC'D BY LOCAL REG. 8-13-69

REGISTRAR'S SIGNATURE Ella Mae Cunningham

25. EMBALMER [signature]

LICENSE NO. 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.. .....

Certificate of Death

STATE OF IDAHO

State File No. 3095
Local Reg. No. 248
Reg. Dist. No. 510

RECEIVED AUG 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 008

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 37 Dartmouth

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

3. NAME OF DECEASED (Type or Print): a. (First) HENRIETTE b. (Middle) ALBERTINA c. (Last) CHRISTINE KLOOSTERBOER

4. DATE OF DEATH: (Month) July (Day) 24 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 3

8. DATE OF BIRTH: October 12, 1892

9. AGE (In years last birthday): 76 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Amsterdam, Netherlands

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Palstra
BIRTHPLACE: Hull, England

14. MOTHER'S MAIDEN NAME: Jacoba H. Van Bevervoorde
BIRTHPLACE: Netherlamds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): *****0

16. SOCIAL SECURITY NO.: 440-32-7650

17. INFORMANT'S OWN SIGNATURE: Rex A White
ADDRESS: Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary emboli — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractured hip — two weeks
DUE TO (c) Fall

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): about home 01
21c. (CITY, TOWN, OR TOWNSHIP) City 13 (COUNTY) 031 (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fell over a dog leash

22. *I hereby certify that I attended the deceased from* Jan 17, 1969, *to* July 24, 19 69, *that I last saw the deceased alive on* July 24, 19 69, *and that death occurred at* 2:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L S Call MD
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: July 28, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: July 28, 1969
24c. NAME OF CEMETERY OR CREMATORY: Aultorest Memorial Corp
24d. LOCATION (City, town, or county): Ogden (State): Utah

DATE REC'D BY LOCAL REG. AUG 4 1969
REGISTRAR'S SIGNATURE: Linda Ainsworth, Deputy
25. EMBALMER: Grant Henderson
LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3096
Local Reg. No. 368
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 030 Bannock AUG 22 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lava Hot Springs Bureau
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Valley View Rest Home 021

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 030 McCammon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) WALLACE b. (Middle) BIRD c. (Last) HOWELL

4. DATE OF DEATH (Month) (Day) (Year) July 25, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Mar. 1, 1882

9. AGE (In years last birthday) 87
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Clifton, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry N. Howell
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Elizabeth Bird
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0 (If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE X Roland A Howell ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 1951, to 5-9, 1969, that I last saw the deceased alive on 5-9, 1969, and that death occurred at 7:45 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [signature]

23b. ADDRESS Dayton Idaho

23c. DATE SIGNED 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jul.29,1969

24c. NAME OF CEMETERY OR CREMATORY Clifton Cemetery

24d. LOCATION (City, town, or county) (State) Clifton, Idaho

DATE REC'D BY LOCAL REG. 8-11-69

REGISTRAR'S SIGNATURE Ila Mae Cunningham

25. EMBALMER Theron Miller

LICENSE NO. E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3097
Local Reg. No. 253
Reg. Dist. No. 510

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello Bureau
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Whitman Hotel

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEONARD	A.	LUNDSTROM	July 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	widowed 2	June 10, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
06 St. Anthony Hospital		Richmond, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles A. Lundstrom	Sweden	Anna Olsen	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	0	518 18 6510	Evan C. Lundstrom	Soda Spgs. Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 185X Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Carcinoma of Prostate — 5 Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/14/64	Carcinoma of Prostate	Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug, 1967, to July 27, 1967, that I last saw the deceased alive on July 27, 1969, and that death occurred at 9:15 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
190 C.C. Groom M.D.	605 E. Center	7/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jul. 29, 1969	Richmond Cemetery	Richmond, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 11 1969	Gloria Oputa	Thurman Miller	E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 1 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3098
Local Reg. No. 265
Reg. Dist. No. 511

BIRTH NO.

RECEIVED AUG 22 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lava Hot Springs (Bur township)
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valleyview Nursing Home 02

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bennock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lava Hot Srpings
d. STREET ADDRESS (If rural, give location): Valleyview Nursing Home

3. NAME OF DECEASED (Type or Print): a. (First) AMY b. (Middle) MAY c. (Last) ARMSTRONG

4. DATE OF DEATH: (Month) July (Day) 26 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: March 20, 1876

9. AGE (In years last birthday): 93
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: *****

11. BIRTHPLACE (State or foreign country): (No data) Oklahoma

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: No Data
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: No Data
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes, give war or dates of service): ******

16. SOCIAL SECURITY NO.: 518-68-5824

17. INFORMANT'S OWN SIGNATURE: Personal records
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerosis

DUE TO (c) Patient has been blind and deaf for years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4369

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec., 1966, *to* June 24, 1969, *that I last saw the deceased alive on* 5-4-, 1969, *and that death occurred at* 6:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]

23b. ADDRESS: Downey, Idaho

23c. DATE SIGNED: July 28, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 28, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 7-11-69

REGISTRAR'S SIGNATURE: Ella Mae Cunningham

25. EMBALMER: [signature]

LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Oct 28, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3099
Local Reg. No. 247
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Bannock			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Montana	b. COUNTY: Fergus
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello	c. LENGTH OF STAY (In this place): 3 mos		b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Lewistown	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Nursing Home			d. STREET ADDRESS (If rural, give location): Rt 1, Box 22A	

3. NAME OF DECEASED (Type or Print)	a. (First): Astor	b. (Middle): Marcus	c. (Last): Stendal	4. DATE OF DEATH (Month): July	(Day): 26,	(Year): 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: March 6, 1890	9. AGE (In years last birthday): 79	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Transport. Co.	10b. KIND OF BUSINESS OR INDUSTRY: Transportation		11. BIRTHPLACE (State or foreign country): Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Peter A. Stendal	BIRTHPLACE: Denmark		14. MOTHER'S MAIDEN NAME: Secilie Markusen	BIRTHPLACE: Denmark		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 517-36-9653		17. INFORMANT'S OWN SIGNATURE: David R. Eike, Pocatello, Idaho	ADDRESS		

4121

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac failure	3 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic myocarditis	3 yrs
DUE TO (c)	Hypertension & recurrent CVA	1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?		

22. *I hereby certify that I attended the deceased from* May, 19 65, *to* July 26, 19 69, *that I last saw the deceased alive on* July 26, 19 69, *and that death occurred at* 10:55a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John R. McMahon, M.D.	23b. ADDRESS: Pocatello, Idaho	23c. DATE SIGNED: 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: July 29,69	24c. NAME OF CEMETERY OR CREMATORY: Brainerd Cem.	24d. LOCATION (City, town, or county) (State): Brainerd, Minn.	
DATE REC'D BY LOCAL REG.: July 30,1969	REGISTRAR'S SIGNATURE: Gloria Dopita	25. EMBALMER: John P. Grossman		LICENSE NO.: E 292

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Downard Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
OCT 22 1969
Bureau of Vital Statistics

State of Idaho } ss.
County of Bannock }

Certificate No. _____

Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Astor Marcus Stendal (Name on Original Certificate) who died (Was Born or Died) on July 26, 1969 (Date of Event)
in Pocatello (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by _____ (Bible Record, Insurance Policy, Etc.) prepared on _____ (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Legal place of residence	State of Idaho County of Bannock 1002 Samuel #67, Pocatello	State of Montana County of Fergus Rural-Lewistown Rt. 1 Box 22A

Subscribed and sworn to before me this 20th day of October 1969

John P. Lamm

Notary Public, residing at Pocatello, Idaho
My commission expires June 20, 1972
(Seal)

Signed David F. Link Son in law
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

5047 Cherokee, Pocatello, Idaho 83201
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Bannock }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 20th day of October, 1969

John P. Lamm

Notary Public, residing at Pocatello, Idaho
My commission expires June 20, 1972
(Seal)

Signed Theodore F Anderson
(Signature of Any Credible Person)

1420 So. 2nd, Pocatello, Idaho 83201
(Street Address, City, State)

STATE OF IDAHO

DEPARTMENT OF PUBLIC HEALTH, BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho — Certificate No. .....

County of Bannock — Date Filed .....

RECEIVED
OCT 22 1980

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)

for Lutor Marcus Iscoffel (Name on Original Certificate) who died (Was Born or Died) on July 26, 1959 (Date of Event)

in Pocatello (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Date Filed)

EACTS TO BE CORRECTED (Name, Birth Date, Correct Death, Etc.)	FROM (As on Original)	TO (As Correct Fact)
Legal place of Residence	State of Idaho	State of Montana
	County of Bannock	County of Fergus
	[illegible]	[illegible]

Subscribed and sworn to before me this 20th day of October 1959

Signed [signature] (Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other certifying person)

Notary Public residing at Pocatello, Idaho
My commission expires June 20, 1972 (Seal)

1947 Cherokee, Pocatello, Idaho (Street Address, City, State)

SUBSTITUTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Bannock

(This Affidavit Must Also Be Executed (See Chapter 13, 1957 Idaho Session Laws))

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge

Subscribed and sworn to before me this 20th day of October 1959

Signed [signature] (Signature of Any Certifying Person)

Notary Public residing at Pocatello, Idaho
My commission expires June 20, 1972 (Seal)

1420 So. 2nd, Pocatello, Idaho (Street Address, City, State)

State File No. 3099
Local Reg. No. 247
Reg. Dist. No. 510

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 030 AUG - 5 1969 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 3 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Nursing Home 299

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1002 Samuel

3. NAME OF DECEASED (Type or Print)
a. (First) Astor
b. (Middle) Marcus
c. (Last) Stendal

4. DATE OF DEATH (Month) (Day) (Year) July 26, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Mar. 6, 1890
9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Transport. Co. 10
10b. KIND OF BUSINESS OR INDUSTRY Transportation
11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter A. Stendal
BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Secilie Markusen
BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 517-36-9653
17. INFORMANT'S OWN SIGNATURE David R. Eike
ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4121

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arterio-sclerotic myocarditis — 3 yrs
DUE TO (c) Hypertension, & recurrent CVA — 1 year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1965, *to* July 26, 1969, *that I last saw the deceased alive on* July 26, 1969, *and that death occurred at* 10:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE John R. McMahon M.D. 347 (Degree or title)
23b. ADDRESS Pocatello Idaho
23c. DATE SIGNED 7/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Jul. 29-69
24c. NAME OF CEMETERY OR CREMATORY Brainerd Cem.
24d. LOCATION (City, town, or county) (State) Brainerd, Minn.

DATE REC'D BY LOCAL REG. JUL 30 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER John P. Grossman
LICENSE NO. E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3100
Local Reg. No. 354
Reg. Dist. No. 5 10

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY 031 Bannock

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello

c. LENGTH OF STAY (In this place) 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital 019

d. STREET ADDRESS (If rural, give location) 796 Wayne

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SAMUEL	L.	COX	July 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	married 3	Aug. 22, 1893	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician and Car 24	inspector	Ogden, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Cox		Mary Watson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	XXXX 8		A.T. Rust	704 Birch

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — Chronic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 27, 19 69 *to* July 27, 19 69, *that I last saw the deceased alive on* July 27, 19 69 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	L S Call MD	Box 852-Pocatello-Idaho	7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jul. 30, 1969	Arimo Cemetery	Arimo, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 11 1969	[signature]	Theron Spiller	E-334

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH–63021

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3101
Local Reg. No. 255
Reg. Dist. No. 5-0

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY 03 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello Rur. au
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 294 Hillcrest Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 735 North 13th Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY	E.	RANDALL	July 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	widowed 2	May 19, 1883	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Lady 24	Avon Products	Plain City, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christen Olsen		Andrea Poulsen	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0 XXXX	519 14 9013	E. L. Randall	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebrovascular insufficiency & thrombosis — INTERVAL BETWEEN ONSET AND DEATH: chronic

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec. 28, 1951, *to* July 27, 1969, *that I last saw the deceased alive on* July 27, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
077 L S Call MD	Box 852-Pocatello-Idaho	7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jul. 30, 1969	Ogden Cemetery	Ogden, Weber, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 1 1 1969	Elona Davis	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3102
Local Reg. No. 259
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 356 Fairmont Street

3. NAME OF DECEASED (Type or Print)
a. (First): AMY
b. (Middle): JANE
c. (Last): HAISLIP

4. DATE OF DEATH (Month) July (Day) 30 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 10, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Philipsburg Kansas
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME BIRTHPLACE: Francis M. Lowry
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Manda Bugg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0 *****
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Raymond H. Haislip — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arterio sclerotic cerebral vascular Disease — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* July 30, 1969, *that I last saw the deceased alive on* July 30, 1969, *and that death occurred at* 6:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David C. Miller, MD 362
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Aug. 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

AUG 13 1969

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

AUG 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3103
Local Reg. No. 257
Reg. Dist. No. 511

BIRTH NO.

RECEIVED
AUG 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Nursing Home 299

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Inkom
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) JACOB b. (Middle) WILBUR c. (Last) JONES
4. DATE OF DEATH (Month) (Day) (Year) July 31, 1969
5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Feb.20, 1877
9. AGE (In years last birthday) 92
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman 10
10b. KIND OF BUSINESS OR INDUSTRY U.P.R.R.
11. BIRTHPLACE (State or foreign country) Kanawha Co.,W.Virg.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Lewis Jones BIRTHPLACE W.Virginia
14. MOTHER'S MAIDEN NAME Mary Susan Brightwell BIRTHPLACE W.Virginia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0 XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE ADDRESS X Wilbur F Jones

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 3 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1968, to July 31, 1969, that I last saw the deceased alive on July 31, 1969, and that death occurred at 9 P m., from the causes and on the date stated above.

23a. SIGNATURE [illegible] Randall (Degree or title) MD
23b. ADDRESS Pocatello Ida
23c. DATE SIGNED 8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug.4,1969
24c. NAME OF CEMETERY OR CREMATORY Cedar Butte Cemetery
24d. LOCATION (City, town, or county) (State) Annis, Idaho

DATE REC'D BY LOCAL REG. AUG 11 1969
REGISTRAR'S SIGNATURE Elona Davis
25. EMBALMER Theron Miller
LICENSE NO. E-534
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3104
Local Reg. No. 260
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 15 1969

1. PLACE OF DEATH
a. COUNTY: Bannock 057
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 510 South Main Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 710 Franklin Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Demetrios
b. (Middle): B. (also known as)
c. (Last): VARKAS

4. DATE OF DEATH (Month) (Day) (Year): July 31 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 2, 1887
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Candy Maker-Retired 06
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (State or foreign country): Agridion, Greece
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Vascillios Varkas — BIRTHPLACE: Greece
14. MOTHER'S MAIDEN NAME: Ekaterina Alexopoulous — BIRTHPLACE: Greece

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW 1 1 — (If yes, give war or dates of service): Army 3
16. SOCIAL SECURITY NO.: 519-36-1870
17. INFORMANT'S OWN SIGNATURE: Amalia Varkas — ADDRESS: Boise, Idaho

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Probable Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): History of Coronary Artery Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~XXXXXXXXXXXX, 19XXX, to XXXXXXXXXXXX, 19XXXX~~ *that I last saw the deceased dead alive on* July 31, 1969, *and that death occurred at* 5:40p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gustav [signature] 583 — Bannock County Coroner
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Aug. 1, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: AUG 14 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3105
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier
c. LENGTH OF STAY (In this place): 1 day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Crest Motel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Coos Bay
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coos Bay
d. STREET ADDRESS (If rural, give location): 466 No 4th Court.

3. NAME OF DECEASED (Type or Print)
a. (First): Collin
b. (Middle): McKinney
c. (Last): Bower

4. DATE OF DEATH (Month) (Day) (Year): July 1st 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 24 1901
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired truck 27
10b. KIND OF BUSINESS OR INDUSTRY: Driver
11. BIRTHPLACE (State or foreign country): Harrison Ark.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William A Bower
BIRTHPLACE: Ill.
14. MOTHER'S MAIDEN NAME: Ida McKinney
BIRTHPLACE: Ark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes 1 World War 1
16. SOCIAL SECURITY NO.: 540-14-8676
17. INFORMANT'S OWN SIGNATURE: Helene Stack Bower
ADDRESS: Coos Bay Ore.

4299

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart attack — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Emphysema — many years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 6:30 A.m., from the causes and on the date stated above.*

23a. SIGNATURE: Paul C. Daems 126 (Degree or title) M.D.
23b. ADDRESS: Montpelier, Idaho
23c. DATE SIGNED: 7-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: July 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Cemetery
24d. LOCATION (City, town, or county) (State): Coos Bay Oregon

DATE REC'D BY LOCAL REG.: 7/5/69
REGISTRAR'S SIGNATURE: Ruby Gortcinsky
25. EMBALMER: Nile Matthews
LICENSE NO.: E 359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3106
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED JUL 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bear Lake 04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VirDay Motel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Colorado 06
b. COUNTY: El Paso
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fountain
d. STREET ADDRESS (If rural, give location): Kelly's Trailer Park

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Louis	Wilford	Campbell	July	11	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Oct. 15, 1918	50				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
contractor //	building	Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oliver Campbell	Illinois	Bertha Sheehan	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes / World War II & Korean 955X		Mrs. Louis Campbell	Fountain Colo.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Wound, head, gunshot — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) probable suicide
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12 July 69	Wound head, massive, gunshot	YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
2		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12 July, 1969, *to* ———, 19—, *that I last saw the deceased alive on* ———, 19—, *and that death occurred at* ——— *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward E. Fisher MD	Pocatello Idaho	12 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal	July 13 1969	Shiloh Cemetery	near Plainsville, Illinois

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 12, 1969	Ruby Gortcenicky	Nile Matthews	E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 2 5 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3107
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nounan
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nounan
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) c. (Last) Minnig

4. DATE OF DEATH (Month) (Day) (Year) July 11, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 12, 1893
9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming & Custom Work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Montpelier Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Minnig BIRTHPLACE Switzerland
14. MOTHER'S MAIDEN NAME Elizabeth Murri BIRTHPLACE Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War I & II
16. SOCIAL SECURITY NO. 565-28-8882
17. INFORMANT'S OWN SIGNATURE Ethel Minnig, Georgetown, Idaho ADDRESS

4119

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-4, 1968, *to* 7-11, 1969, *that I last saw the deceased alive on* 6-30, 1969, *and that death occurred at* 5:00 *pm., from the causes and on the date stated above.*

23a. SIGNATURE Paul B. Loewes 126 (Degree or title) M.D.
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 15, 1969
24c. NAME OF CEMETERY OR CREMATORY Nounan Cemetery
24d. LOCATION (City, town, or county) (State) Nounan Idaho

DATE REC'D BY LOCAL REG. 7-14-69
REGISTRAR'S SIGNATURE Ruby Gortcinsky
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3108
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

AUG 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier
c. LENGTH OF STAY (If not in hospital or institution, give street address or location): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hospital 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Wyoming 51
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cokeville
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Eugene
b. (Middle): Bradford
c. (Last): Birch

4. DATE OF DEATH (Month) (Day) (Year): July 24 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Feb. 3, 1919
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence Allen Birch — BIRTHPLACE: Montpelier, Ida.
14. MOTHER'S MAIDEN NAME: Edith Mae Bourne — BIRTHPLACE: Cokeville, Wyo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes 1 — (If yes, give war or dates of service): World War II 4109
16. SOCIAL SECURITY NO.: 520-14-0549
17. INFORMANT'S OWN SIGNATURE: Nunn L. Birch — ADDRESS: Cokeville, Wyo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic — 10 yrs
DUE TO (c): Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1968, *to* 24 July 1969, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 1:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 458
23b. ADDRESS: [signature]
23c. DATE SIGNED: 8/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: July 28, 1969
24c. NAME OF CEMETERY OR CREMATORY: Cokeville Cemetery
24d. LOCATION (City, town, or county) (State): Cokeville Wyoming

DATE REC'D BY LOCAL REG.: 8-4-69
REGISTRAR'S SIGNATURE: Ruby Gortcinsky
25. EMBALMER: Nile Matthews
LICENSE NO.: E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 27 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3109
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bern Idaho
c. LENGTH OF STAY (in this place) 2 Weeks 314
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at Home of Daughter 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Nevada 29
b. COUNTY Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Las Vegas
d. STREET ADDRESS (If rural, give location) 2904 East Marlin Ave

3. NAME OF DECEASED (Type or Print)
a. (First) Agnes
b. (Middle) Marion
c. (Last) Mott

4. DATE OF DEATH (Month) (Day) (Year) July 26, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Sept 25, 1883
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Toquerville, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lymas Dodge — BIRTHPLACE Toquerville Utah
14. MOTHER'S MAIDEN NAME Helen L. Davis — BIRTHPLACE Toquerville Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No 2 — (If yes, give war or dates of service) None 0
16. SOCIAL SECURITY NO. 530-10-4616A
17. INFORMANT'S OWN SIGNATURE Norman E. Mott — ADDRESS 2009 E Stewart Las Vegas, Nev.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apparent Heart attack — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) From family history
DUE TO (c) She has had heart trouble for some time

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. No Struggle, died instantly

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 10 P. m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Nile Matthews 583 Coroner 4
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 7/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE July 27 1969
24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
24d. LOCATION (City, town, or county) Las Vegas Nevada (State)

DATE REC'D BY LOCAL REG. 7/27/69
REGISTRAR'S SIGNATURE Ruby Gortcinsky
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3110
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
c. LENGTH OF STAY (If in place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bloomington, Idaho.
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Albert
b. (Middle) Victor
c. (Last) Reese

4. DATE OF DEATH (Month) (Day) (Year) July 28 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 2
8. DATE OF BIRTH Nov. 11, 1891
9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY Stock
11. BIRTHPLACE (State or foreign country) Bloomington, Ida.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lotwick Reese BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Mary Jane Johns BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) None 0
16. SOCIAL SECURITY NO. 530-22-8665
17. INFORMANT'S OWN SIGNATURE Lula P. Reese ADDRESS Bloomington Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of Ascending Colon — INTERVAL BETWEEN ONSET AND DEATH 4 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1966, *to* July, 1969, *that I last saw the deceased alive on* 7-27, 1969, *and that death occurred at* 2:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 126 Paul A. Davies M.D.
23b. ADDRESS Mont. Ida.
23c. DATE SIGNED 8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 1 1969
24c. NAME OF CEMETERY OR CREMATORY Bloomington Cemetery
24d. LOCATION (City, town, or county) (State) Bloomington Idaho

DATE REC'D BY LOCAL REG. 8-4-69
REGISTRAR'S SIGNATURE Ruby Gortcinsky
25. EMBALMER Vile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3111
Local Reg. No. 34
Reg. Dist. No. 130

Certificate of Death

RECEIVED
JUL 24 1969
Bureau of V

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): 4 years 04
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ted Bruce residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah 050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RFD # 2 Farmington, Wash. rural
d. STREET ADDRESS (If rural, give location): State line road 6 miles west of Tensed, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): Raymond
b. (Middle): Edson
c. (Last): Anyan

4. DATE OF DEATH (Month) (Day) (Year): July 10, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 2
8. DATE OF BIRTH: March 28, 1910
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm hand 04
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Creston, Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ray Alvin Anyan — BIRTHPLACE: --
14. MOTHER'S MAIDEN NAME: Minnie Watson — BIRTHPLACE: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 533 05 2442
17. INFORMANT'S OWN SIGNATURE: Walt Anyan — ADDRESS: Reardan Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 10:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B. A. Rapp M.D. 428
23b. ADDRESS: St. Maries, Ida
23c. DATE SIGNED: 7-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal-burial
24b. DATE: 7-14-1969
24c. NAME OF CEMETERY OR CREMATORY: Reardan cemetery
24d. LOCATION (City, town, or county) (State): Reardan, Washington

DATE REC'D BY LOCAL REG.: July 21, 1969
REGISTRAR'S SIGNATURE: Donna Brown
25. EMBALMER: H E Kimball — LICENSE NO.: E269

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Kimball Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3112
Local Reg. No. 35
Reg. Dist. No. 130

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 24 1969 Bureau of Vital

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fernwood
LENGTH OF STAY (in this place): 9 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fernwood 050
d. STREET ADDRESS (If rural, give location): General Delivery

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Laverne	Eugene	Trimble	July	10	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 2	June 29, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Trimble — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Etta May — BIRTHPLACE: unavailable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2
(If yes, give war or dates of service): 0 none
16. SOCIAL SECURITY NO.: 536-03-0906
17. INFORMANT'S OWN SIGNATURE: Dixie Mahaney — ADDRESS: 11 W. 27th Spokane

MEDICAL CERTIFICATION

4/69

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA *19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B. A. Rapp 7-28	M.D.	St. Maries	7-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 15, 1969	Woodlawn	St. Maries Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 21, 1969	Donna Brown	Gerald E. Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3113
Local Reg. No. 37
Reg. Dist. No. 130

RECEIVED AUG 18 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY (in this place): 86 days 303
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Vista Conv. Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Benewah 050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): 7th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Minnie	Almeda	Whitehead	July 26 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 3, 1888	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Washington	U.S.A.

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
Not Available	Not Available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-60-4826	L. F. Whitehead	St. Maries Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1960, *to* 7-26, 1969, *that I last saw the deceased alive on* 7-26, 1969, *and that death occurred at* 7:50p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. A. Rady M.D. 7/28	St. Maries, Idaho	8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 30, 1969	Woodlawn	St. Maries Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 12, 1969	Donna Brown	Gerald Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3114
Local Reg. No. 103
Reg. Dist. No. 601

BIRTH NO.

RECEIVED AUG - 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Firth
c. LENGTH OF STAY (In this place) Minutes 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Snake River near Firth, Idaho 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) West Main & Pacific

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Harold	Francis	Marantette	June 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	JUne 23, 1915	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Automotive	Augusta, Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph H. Marantette	Mendon, MIch.	Vera Ann Schmidt	Waverly, MInn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWII	535-03-6732	Virginia Marantette	Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8309

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Drowning — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) boat capsized in Snake River
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Snake River 18	Near Firth, Bingham 060 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
June 29, 1969 4 p m.		Boat capsized in Snake River

22. *I hereby certify that I attended the deceased* XXX July 6 about 19 69, XXXX

AUG 5 1969

OCT 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 23 1969 Bureau of Vital Statistics

State File No. 3115
Local Reg. No. 97
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
LENGTH OF STAY (In this place) 3 hours 403
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Firth
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First) Ralph b. (Middle) L. c. (Last) Heaton
4. DATE OF DEATH (Month) (Day) (Year) July 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	April 17, 1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Agriculture	Firth, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Heaton	Cache Valley, Utah	Nora Amor;	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	519-42-8605	Nora Gilley	Chester, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

900X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severe Hyperpyrexia while stacking hay — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractured Pubic bone — 6 hrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from _____, 19____, to July 1, 19 69, that I last saw the deceased alive on July 1, 19 69, and that death occurred at 5:30p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean Packer 403 M.D.	Blackfoot, Idaho	July 7, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 7, 1969	Grove City Cemetery	Blackfoot, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 18, 1969	Dorothy J. Jones	L. Dean Hill	E-466

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SANDBERG-HILL FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3116
Local Reg. No. 95
Reg. Dist. No. 60 0

BIRTH NO.

RECEIVED JUL 1 5 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
c. LENGTH OF STAY IN THIS PLACE: 35 yrs. 135
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. #3, Hepworth Lane 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
d. STREET ADDRESS (If rural, give location): Rt. #3, Hepworth Lane

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	L.	Hansen	July 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
female	white	widowed 2	April 23, 1883	86	2	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Lago, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Lusher	Burlington, Vermont	Olena Marie Christensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 0	518-60-5844	Earl A. Very	Blackfoot, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Arteriosclerotic cardiovascular disease.	10 years.
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Diverticulosis, severe. Fibrosis, both lungs. ~~Diabetes mellitus.~~	all 10 years.

4124

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 17 Apr., *19* 62, *to* 2 July, *19* 69, *that I last saw the deceased alive on* 2 July, *19* 69, *and that death occurred at* 12:30a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Walter G Hoge 234	M.D.	Blackfoot, Idaho	7-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-7-69	Grove City Cemetery	Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 9 1969	Dorothy J. Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3117
Local Reg. No. 94
Reg. Dist. No. 60 0

RECEIVED JUL 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 30yr4mo 30
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) --

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DENICE	HILMA	STANGER	July	2	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Divorced 2	12-12-1917	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Prostitute 30		Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dewey Arnold	Idaho	Helena George	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0		Med. Records-State Hospital South	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 1830
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant cystadenoma of the ovaries (cystadenocarcinoma of the ovaries) with metastasis to the mesenteric lymph nodes and to the liver and other organs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2 July, 19 69, *to* 2 July, 19 69, *that I last saw the deceased alive on* 2 July, 19 69, *and that death occurred at* 11:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ralph Woates 183 MD	State Hospital South - Blackfoot, Idaho	3 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 5, 1969	Sutton Cemetery	Archer Madison Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 9 1969	Dorothy L. Jones	Bruce A. Eckersell Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: APR 30 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3118
Local Reg. No. 96
Reg. Dist. No. 600

RECEIVED JUL 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN: Blackfoot
c. LENGTH OF STAY (in this place): 31yr6mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell 32
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) EDWIN c. (Last) EDDIE

4. DATE OF DEATH: (Month) July (Day) 6 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: June 2 1910

9. AGE (In years last birthday): 59 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Edwin Eddie BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Dasher BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): 2 0

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mary Rayne ADDRESS: Med. Records-State Hospital South

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Hypertension & Renal Disease — 2 yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 July, 19 69, *to* 3 July, 1969, *that I last saw the deceased alive on* 3 July, 1969, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ralph G. Coates (Degree or title) M.D.

23b. ADDRESS: State Hospital South - Blackfoot, Idaho

23c. DATE SIGNED: 7 Jul 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 8, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pioneer

24d. LOCATION (City, town, or county) (State): Rigby Jefferson Idaho

DATE REC'D BY LOCAL REG.: July 15, 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Bruce A. Eckersell LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 23 1969 Bureau of Vital Statistics

State File No. 3119
Local Reg. No. 95
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
LENGTH OF STAY (In this place) 1 day 30/
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sterling
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Amos	Duane	Webb	July 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	April 17, 1920	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Basalt, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
W. A. Webb	Orderville, Utah	Coral Kelsey	Milburn, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 8	0	519-14-3500	Marjorie Webb	Sterling, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1963 *to* July 14, 1969, *that I last saw the deceased alive on* July 14, 1969, *and that death occurred at* 4:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. E. Mullen 361	M.D.	Blackfoot, Idaho	July 17, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 18, 1969	Springfield Cemetery	Springfield, Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 18, 1969	Dorothy J. Jones	John C. Sandberg	E-280

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3120
Local Reg. No. 98
Reg. Dist. No. 600

RECEIVED AUG - 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 2½ yrs / 03

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
d. STREET ADDRESS (If rural, give location)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital

3. NAME OF DECEASED (Type or Print) a. (First) CLARENCE b. (Middle) B. c. (Last) SPRAKER

4. DATE OF DEATH (Month) (Day) (Year) July 20, 1969

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 17, 1894
9. AGE (In years last birthday) 74
IF UNDER 1 YEAR Months 10 Days 3
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, Equipment operator.
10b. KIND OF BUSINESS OR INDUSTRY Farm, Cons.
11. BIRTHPLACE (State or foreign country) Mt. Pleasant, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Otto B. Spraker
BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Margaret McDowell
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 518-09-2166A
17. INFORMANT'S OWN SIGNATURE Vera Spraker
ADDRESS Aberdeen, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Influenza — INTERVAL BETWEEN ONSET AND DEATH: One day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS arteriosclerosis arthritis
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 1969, to July 20, 1969, that I last saw the deceased alive on June 1, 1969, and that death occurred at _____ p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial
24b. DATE July 23, 1969
24c. NAME OF CEMETERY OR CREMATORY Aberdeen Cemetery
24d. LOCATION (City, town, or county) (State) Aberdeen, Idaho

DATE REC'D BY LOCAL REG. July 30, 1969
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER H. L. Davis
LICENSE NO. E-253
FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG - 4 1969 Bureau of Vital Statistics

State File No. 3121
Local Reg. No. 99
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): years/00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 190 South Stout St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 190 South Stout St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LOWAVE	ANN	WINSCHELL	July 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	married 3	July 22, 1969	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Tecumseh, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Willeford		Margaret Wyatt	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	0	519-22-0807	Keith W. Winschell	Blackfoot, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 28, 1968, to July 22, 1969, that I last saw the deceased alive on July 22, 1969, and that death occurred about 10 p.m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
J. M. Wither 569 (Degree or title) M.D.	Blackfoot, Idaho	July 25, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
burial	July 26, 1969	Grove City Cemetery	Blackfoot	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 1, 1969	[signature]	[signature]	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 5 1969

AUG 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 8 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3122
Local Reg. No. 100
Reg. Dist. No. 600

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG - 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 4 mon. 204
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Apt. #3 Fargo Apts.

3. NAME OF DECEASED (Type or Print)
a. (First): NINA
b. (Middle): T.
c. (Last): NEELEY

4. DATE OF DEATH (Month) (Day) (Year): July 24 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 6 March 1903
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cosmetologist 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Neils Hansen — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Eva Hockstrasser — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518 30 8879
17. INFORMANT'S OWN SIGNATURE: Mary Payne — ADDRESS: Med. Records-State Hospital South

4270

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — Weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 21 March, 1969, *to* 24 July, 1969, *that I last saw the deceased alive on* 24 July, 1969, *and that death occurred at* 10:10am., *from the causes and on the date stated above.*

23a. SIGNATURE* (Degree or title): A. E. Miller Jr. M.D. 361
23b. ADDRESS: State Hospital South-Blackfoot, Idaho
23c. DATE SIGNED: 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 28 69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: Aug 1, 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Dean Hill
LICENSE NO.: E-466
FIRM NAME: Henderson Funeral Home, Pocatello

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 4 1969 Bureau of Vital Statistics

State File No. 3123
Local Reg. No. 102
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 20 days 320
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 794 South Shilling St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HAROLD	B.	ASTLE	July 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married 3	June 17, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stock buyer 24	Livestock	Rigby, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jesse Butler Astle		Annie Greenwood	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	0			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 485X Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Atherosclerosis Unknown — years / weeks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 21 July, 1967, to July 27, 1969, that I last saw the deceased alive on July 27, 1969, and that death occurred at 4:00a m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. E. Miller	M.D.	Blackfoot, Idaho	July 28, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
burial	August 2, 1969	Basalt Cemetery	Firth,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1, 1969	Jack D. Gilmore	John C. Sandberg	E-280

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

RECEIVED
AUG - 4 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3124
Local Reg. No. 101
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 6 mo's
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Nursing Home 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Bingham 061
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot 06
d. STREET ADDRESS (If rural, give location): 285 Rich Street

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) Henry c. (Last) Felt

4. DATE OF DEATH: (Month) July (Day) 27, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Oct. 30, 1882

9. AGE (In years last birthday): 86 IF UNDER 1 YEAR Months: 8 Days: 27 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer and Insurance

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm & Insurance

11. BIRTHPLACE (State or foreign country): Huntsville, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Felt
BIRTHPLACE: Harbor of Kiel, Germany

14. MOTHER'S MAIDEN NAME: Charlotta Cathrine Bjorkholm
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-30-7149

17. INFORMANT'S OWN SIGNATURE: Golden W. Felt ADDRESS: Box 988 Blackfoot

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 15, 1969, *to* July 27, 1969, *that I last saw the deceased alive on* July 27, 1969, *and that death occurred at* 8:25 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-30-69

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.: JUL 31 1969

REGISTRAR'S SIGNATURE:

25. EMBALMER: Howard Packham LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form PH-63021

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 28 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3125
Local Reg. No. 21
Reg. Dist. No. 40

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
LENGTH OF STAY (in this place): 006
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location): 518 4th Ave. South

3. NAME OF DECEASED (Type or Print): a. (First) GLORIA b. (Middle) JEAN c. (Last) RUTTER

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Oct. 10, 1925

9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Des Moines, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Leo S. Berry — Winterset, Iowa

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: FLorence McBride — Twin Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 720-03-4583

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Hailey, Ida

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ASPIRATION GASTRIC CONTENTS — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) BRONCHO - ESOPHAGEAL FISTULA — 3 WKS

DUE TO (c) OAT CELL CARCINOMA, LUNG — 1 YEAR

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JULY, 19 6[illegible], *to* 2 JULY, 19 69, *that I last saw the deceased alive on* 2 JULY, 19 69, *and that death occurred at* 4:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD

23b. ADDRESS: Sun Valley, Idaho

23c. DATE SIGNED: 7/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/7/69

24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery

24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 7/25/69

REGISTRAR'S SIGNATURE: Robert H. Wright per [illegible]

25. EMBALMER: Keith Bird — LICENSE NO.: E. 372

FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3126
Local Reg. No. 77
Reg. Dist. No. 410

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Blaine 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
c. LENGTH OF (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Blaine 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
d. STREET ADDRESS (If rural, give location) 303 1st Ave. South

3. NAME OF DECEASED (Type or Print)
a. (First) HELENA
b. (Middle) SNIDER
c. (Last) VOUGHT

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH June 11, 1894
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Ketchum, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter Snider — BIRTHPLACE Italy
14. MOTHER'S MAIDEN NAME Maria J. UNK. — BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 — (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Carolyn G. Malleas — ADDRESS Salt Lake, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ASHD

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 2: A m., from the causes and on the date stated above.*

23a. SIGNATURE Robert A. Gwinner 577 (Degree or title) MD 1
23b. ADDRESS Box 37 Hailey Idaho
23c. DATE SIGNED 7/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 7/10/69
24c. NAME OF CEMETERY OR CREMATORY Hailey Cemetery
24d. LOCATION (City, town, or county) Hailey, Idaho (State)

DATE REC'D BY LOCAL REG. July 15/69
REGISTRAR'S SIGNATURE Robert H. Wright per CBW
25. EMBALMER Keith Bird Keith Bird
LICENSE NO. E-373
FIRM NAME: Bird Funeral Home Hailey, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 28 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 16 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 30 1979

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3127
Local Reg. No. 7827
Reg. Dist. No. 410

BIRTH NO.

RECEIVED
JUL 17 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Blaine 070

b. CITY OR TOWN: Hailey

c. LENGTH OF STAY (in this place): 7 days 307

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blaine Co. Hospital 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Blaine 070

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey

d. STREET ADDRESS (If rural, give location): 317 East Spruce

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EVA		VASCO	July 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Aug. 23, 1894	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Stanton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Sherbine	Ohio	Martha UNK	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE	ADDRESS
no 20		X Eva Dougherty	Hailey, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion 2509

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ASHD

DUE TO (c) Diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/7, 1969, *to* 7/9, 1969, *that I last saw the deceased alive on* 7/9, 1969, *and that death occurred at* 2:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ralph L. Lewis Jr. MD	Box 37 Hailey Idaho	7/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/12/69	Bellevue Cemetery	Bellevue, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 15 '69	Robert H. Wright per RBW	Keith Bird Keith Bird	E-373

FIRM NAME: Bird Funeral Home Hailey, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3128
Local Reg. No. 2828
Reg. Dist. No. 4-10

BIRTH NO.

RECEIVED STATE OF IDAHO

JUL 17 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN: Ketchum
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ketchum
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) KATHERINE b. (Middle) CORA c. (Last) McMASTER

4. DATE OF DEATH (Month) (Day) (Year): July 10, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married S

8. DATE OF BIRTH: Oct. 20, 1909

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife 07

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Grangeville, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Farrins
BIRTHPLACE: Joplin, Mo.

14. MOTHER'S MAIDEN NAME: Cora Hutsell
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Frank A McMaster
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

8288

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cremation / asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Barbiturate ingestion (presumed - blood barbiturate tests pending)

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Coronary artery disease

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): /

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home 07

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Ketchum, Blaine 070 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 10 1969 6 a.m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?: Smoking in bed after ingestion of seconal (presumed)

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Oscar A Earl MD 583 Coroner 4

23b. ADDRESS: Sun Valley Idaho

23c. DATE SIGNED: 7/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/12/69

24c. NAME OF CEMETERY OR CREMATORY: Ketchum Cemetery

24d. LOCATION (City, town, or county) (State): Ketchum, Idaho

DATE REC'D BY LOCAL REG.: July 16-1969

REGISTRAR'S SIGNATURE: Robert H. Wright per E.B.W.

25. EMBALMER: Keith Bird Keith Bird

LICENSE NO.: E-373

FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3129
Local Reg. No. 749
Reg. Dist. No. 410

BIRTH NO.

RECEIVED
JUL 17 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
c. LENGTH OF STAY (in this place): ooo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blaine Co. Hospital 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location): 118 West Bullion

3. NAME OF DECEASED (Type or Print): a. (First) ESSIE b. (Middle) IONA c. (Last) GRACE

4. DATE OF DEATH: (Month) July (Day) 11, (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 2

8. DATE OF BIRTH: June 11, 1892

9. AGE (In years last birthday): 77 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: HOME 054

11. BIRTHPLACE (State or foreign country): Auburn, Wyo.

12. CITIZEN OF WHAT COUNTRY?: Usa

13. FATHER'S NAME: Samuel L. Rawlin — BIRTHPLACE: Draper, Utah

14. MOTHER'S MAIDEN NAME: Sarah E. VanOrden — BIRTHPLACE: Kaysville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 518-24-4839

17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Hailey, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilat. pneumonitis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral vascular accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/6, 1969, *to* 7/11, 1969, *that I last saw the deceased alive on* 7/11, 1969, *and that death occurred at* 6:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD — **23b. ADDRESS**: Box 37 Hailey Idaho — **23c. DATE SIGNED**: 7/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 7/15/69 — **24c. NAME OF CEMETERY OR CREMATORY**: Ketchum Cemetery — **24d. LOCATION** (City, town, or county) (State): Ketchum, Idaho

DATE REC'D BY LOCAL REG.: July 15-69 — **REGISTRAR'S SIGNATURE**: Robert N. Wright

25. EMBALMER: Keith Bird [signature] — **LICENSE NO.**: E 373

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev. 1-R.W.

FIRM NAME: Bird Funeral Home Hailey Idaho

JUL 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a complete death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician

Certificate of Death

STATE OF IDAHO

State File No. 3130
Local Reg. No. 22
Reg. Dist. No. 440

BIRTH NO.

RECEIVED JUL 28 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Magic Dam
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ARTHUR	LEO	THIEL	July	16,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Feb. 21, 1902	67	4	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Caretaker 06	Canal Company	Morton, N. Dak.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Thiel	Wisconsin	Rose Weber	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	no	519-01-3195	Jim Thiel	Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 481X Shock 2° to Pneumococcal Sepsis — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumococcal Pneumonia
~~DUE TO (c)~~ Multiple Myelomca

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 7/16, 1969, *that I last saw the deceased alive on* 7/15, 1969, *and that death occurred at* 5:42 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvin Bergin	M.D.	Sun Valley Idaho	7/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-19-1969	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7/26/69	Robert H Wright per LBW	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3131
Local Reg. No. 23
Reg. Dist. No. 410

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Hailey, Idaho
d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print)
a. (First): JOSEPH
b. (Middle): JOHN
c. (Last): SWANER

4. DATE OF DEATH (Month) (Day) (Year): July 21, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: May 7, 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rail road 10
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph J. Swaner — BIRTHPLACE: unk
14. MOTHER'S MAIDEN NAME: Eva Mae Sorenson — BIRTHPLACE: unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes 1 — (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 519-18-7220
17. INFORMANT'S OWN SIGNATURE: x Fred Swaner — ADDRESS: Hailey

4/23

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease (exact etiology of death not determined)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/20, 1969, *to* 7/21, 1969, *that I last saw the deceased alive on* 7/20, 1969 *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 5/ no 1
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: [illegible]/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/28/69
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county): Hailey, Idaho (State)

DATE REC'D BY LOCAL REG.: July 29/69
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird Keith Bird
LICENSE NO.: E-373
FIRM NAME: Bird Funeral Home Hailey, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021 Per E.B.W.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3132
Local Reg. No. 410
Reg. Dist. No. 24

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey, Idaho
d. STREET ADDRESS (If rural, give location): 416 3rd Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First): WILFORD
b. (Middle): LUTHER
c. (Last): KIMBLE

4. DATE OF DEATH (Month) (Day) (Year): July 22, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Nov. 15 1916
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steam Fitter 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fort Benton, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Kimble — BIRTHPLACE: Atlanta, Ga.
14. MOTHER'S MAIDEN NAME: Bulah Coble — BIRTHPLACE: Eldorado, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.: 517-28-1153
17. INFORMANT'S OWN SIGNATURE: Thelma Kimble — ADDRESS: Hailey, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Staphylococcal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Oat cell carcinoma — 18 months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 19 1967 *to* death, 19___, *that I last saw the deceased alive on* 7/22, 19 69, *and that death occurred at* 4 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 151 1
23b. ADDRESS: Sun Valley, Idaho
23c. DATE SIGNED: 7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7/25/69
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetry
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: July 29/69
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird — Keith Bird
LICENSE NO.: E-373
FIRM NAME: Bird Funeral Home Hailey, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021 for CBW

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3133
Local Reg. No. 410
Reg. Dist. No. 25

RECEIVED AUG - 5 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Carey
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hyw. 5mi. E. of Carey 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1445 Antares Drive

3. NAME OF DECEASED (Type or Print) a. (First) NORMAN b. (Middle) SCOTT c. (Last) TRIPP

4. DATE OF DEATH (Month) July (Day) 26 (Year) 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH April 28, 1951

9. AGE (In years last birthday) 18 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 83

10b. KIND OF BUSINESS OR INDUSTRY School

11. BIRTHPLACE (State or foreign country) Pasadena, Calif.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Tripp BIRTHPLACE Cortez, Colo,

14. MOTHER'S MAIDEN NAME Dorthy J. Twiggs BIRTHPLACE Cin . Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 2 0

16. SOCIAL SECURITY NO. 518-64-3611

17. INFORMANT'S OWN SIGNATURE Robert Tripp ADDRESS Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MASSIVE HEAD INJURY — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE / (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street

21c. (CITY, TOWN, OR TOWNSHIP) Carey (COUNTY) Blaine 070 (STATE) Idaho

21d. TIME OF INJURY (Month) July (Day) 26 (Year) '69 (Hour) 12m

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Overturned auto

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE 1583 (Degree or title) Coroner H

23b. ADDRESS Sun Valley, Idaho

23c. DATE SIGNED 8/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3

24b. DATE 7/26/69

24c. NAME OF CEMETERY OR CREMATORY Idaho Falls

24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Aug 4-69

REGISTRAR'S SIGNATURE Robert H. Wright

25. EMBALMER Keith Bird Keith Bird

LICENSE NO. E-373

FIRM NAME: Bird Funeral Home, Hailey, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021 per C.B.W.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 29 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided~~ in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 29 1969

State File No. 3134
Local Reg. No. 352
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boise 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho City Rur
c. LENGTH OF STAY (In this place) Minutes 30 (1
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Grimes Creek & Hiway 21 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 709 West Hays Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DAVID	M.	CURRINGTON	July	3	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed 2	July 16, 1914	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
General Maintence 06		Spirit Lake, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John D. Currington	-----	-------	-----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE AND ADDRESS
No 2 / 0	Unknown	Gary A. Cowger Penitentiary Records

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carbon Monoxide Poisoning — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

9520

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes / No
		X

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
2 Suicide		Idaho City	Boise 080	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.	X	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* did not see alive, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard H. Hanley 583	Coroner 4	Crouch, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	July 9, '69	Syringa Gardens	Boise Ada	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7/26/69	Henrietta Penrod	Dowell D. Demaray	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 22 1969
OCT 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3135
Local Reg. No. #73
Reg. Dist. No.

Certificate of Death

RECEIVED
JUL 3 1 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 5 days 305
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Skagit
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Vernon
d. STREET ADDRESS (If rural, give location): 1702 S. 13th

3. NAME OF DECEASED (Type or Print)
a. (First): Ella
b. (Middle): Kate
c. (Last): Mitchell

4. DATE OF DEATH (Month) (Day) (Year): June 27, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 21, 1891
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter Orwig — BIRTHPLACE: Pennsylvania
14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI 03
16. SOCIAL SECURITY NO.: 369 07 7787 A
17. INFORMANT'S OWN SIGNATURE: Merle S Mitchell — ADDRESS: Mt Vernon Wash

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4279

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac irregularity
DUE TO (c) fibrillation + Atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Post shock - Car accident

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 24, 1969, *to* June 26, 1969, *that I last saw the deceased alive on* June 26, 1969, *and that death occurred at* 2:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J J Munson 382
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 6-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
24b. DATE: June 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mt. Vernon Cemetery
24d. LOCATION (City, town, or county) (State): Mt. Vernon, Washington

DATE REC'D BY LOCAL REG.: 7/29/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 3 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3136
Local Reg. No. #68
Reg. Dist. No.

Certificate of Death

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 1 month 201
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): South Division

3. NAME OF DECEASED (Type or Print)
a. (First): Harry
b. (Middle): Elijah
c. (Last): Arthur

4. DATE OF DEATH (Month) (Day) (Year): July 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 10, 1905
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newspaper delivering
10b. KIND OF BUSINESS OR INDUSTRY: News
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ward Arthur 06 — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Mary Hapner — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0 ------
16. SOCIAL SECURITY NO.: 520 12 0815
17. INFORMANT'S OWN SIGNATURE: Ruth J Arthur — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Same

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-3, 1969, *to* 7-3, 1969, *that I last saw the deceased alive on* 7-3, 1969, *and that death occurred at* 10:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 327 W Mauenau MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 7-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial 3
24b. DATE: July 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Boundary County, Idaho

DATE REC'D BY LOCAL REG.: 7/15/69
REGISTRAR'S SIGNATURE: Dale Anderson
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3137
Local Reg. No. #70
Reg. Dist. No.

Certificate of Death

RECEIVED JUL 22 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (In this place): 6 days 306
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 422 South Florence

3. NAME OF DECEASED (Type or Print)
a. (First): Martha
b. (Middle): Heneritta
c. (Last): Armstrong

4. DATE OF DEATH (Month) (Day) (Year): July 9, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: October 9, 1969
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): North Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Jacobson — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Ragna Holein — BIRTHPLACE: North Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0 ----------
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Edna Spade — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mammary Adenocarcinoma — INTERVAL BETWEEN ONSET AND DEATH: 14 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) metastatic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-3, 1967, *to* 7-9-, 1969, *that I last saw the deceased alive on* 7-9-69, 19__, *and that death occurred at* 9P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J Munson 382 MD
23b. ADDRESS: Sandpoint Ida
23c. DATE SIGNED: 7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county): Sandpoint — (State): Idaho

DATE REC'D BY LOCAL REG.: 7/18/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Moon Funeral Service

DUTIES:

AUG 4 1987

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3138
Local Reg. No. #69
Reg. Dist. No.

RECEIVED JUL 16 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonner 09
b. CITY OR TOWN: Sandpoint
c. LENGTH OF STAY (In this place): 2 days 382
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 09
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Samuels
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Frank b. (Middle) Marvin c. (Last) Saunders

4. DATE OF DEATH: (Month) (Day) (Year): July 9, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 19, 1883

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Saunders
BIRTHPLACE: New York

14. MOTHER'S MAIDEN NAME: Alma Messinger
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No 2

16. SOCIAL SECURITY NO.: 519 12 8447

17. INFORMANT'S OWN SIGNATURE: Dinie Saunders
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Gallbladder — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Cholylithiasis — 10 yrs
DUE TO (c) & Cholycystitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 68 *to* July 69, *that I last saw the deceased alive on* July 8 69, *and that death occurred at* 6A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. Munson MD 382

23b. ADDRESS: Sandpoint Ida

23c. DATE SIGNED: 7-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 11, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 7/15/69

REGISTRAR'S SIGNATURE: Dale Anderson

25. EMBALMER: Dale C. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3139
Local Reg. No. #27
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Shore Lodge Motel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Ohio 36
b. COUNTY: Clarmont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Milford
d. STREET ADDRESS (If rural, give location): 135 Betty Lane

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Kenneth	Raymond	Eakin	7	14	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	April 22, 1916	53		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dep. Reg. Executive-Boy Scouts of America
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin C. Eakin — BIRTHPLACE: Pennsylvania
14. MOTHER'S MAIDEN NAME: Elva Florence Walters — BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 168 07 1198
17. INFORMANT'S OWN SIGNATURE: Dale G. Coffelt — ADDRESS: (Moon Funeral Home)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: same

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-14, 1969, *to* 7-14, 1969, *that I last saw the deceased alive on* never, 19___, *and that death occurred at* 4:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Fred E. Monahan 32 MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: July 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Grove City, Pennsylvania

DATE REC'D BY LOCAL REG.: 7/24/69
REGISTRAR'S SIGNATURE: Hale Gedwan
25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

JUL 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 3 1 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3140
Local Reg. No. 423
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonner 09
b. CITY OR TOWN Sandpoint
c. LENGTH OF STAY (in this place) 10 days 3/0
d. FULL NAME OF HOSPITAL OR INSTITUTION Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner 041
c. CITY OR TOWN Sandpoint
d. STREET ADDRESS (If rural, give location) Route 1, Box 41

3. NAME OF DECEASED (Type or Print) a. (First) Percy b. (Middle) Roy c. (Last) Bloom

4. DATE OF DEATH (Month) (Day) (Year) July 20, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 30, 1907
9. AGE (In years last birthday) 62 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equipment operatbr-Bonner County
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry Bloom
BIRTHPLACE No record

14. MOTHER'S MAIDEN NAME Julie Grubb
BIRTHPLACE No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 2 WW II
16. SOCIAL SECURITY NO. 507 24 9044
17. INFORMANT'S OWN SIGNATURE X Doyle E. Bloom ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute -
DUE TO (c) Atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE L. Munson MD 382 (Degree or title)
23b. ADDRESS Sandpoint
23c. DATE SIGNED 7-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 23, 1969
24c. NAME OF CEMETERY OR CREMATORY Pinecrest Memorial Park
24d. LOCATION (City, town, or county) Sandpoint (State) Idaho

DATE REC'D BY LOCAL REG. 7/29/69
REGISTRAR'S SIGNATURE Hale Anderson

25. EMBALMER Dale G. Coffelt
LICENSE NO. E-501
FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 2 9 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 1 3 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3141
Local Reg. No. #74
Reg. Dist. No.

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

AUG 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 090
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Priest River
c. LENGTH OF STAY (In this place): 5 days 305
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lamb Creek-Priest Lake 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Nebraska 28
b. COUNTY: Douglas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Omaha
d. STREET ADDRESS (If rural, give location): 841 So. 123rd St.

3. NAME OF DECEASED (Type or Print)
a. (First): Anne
b. (Middle): Leslie
c. (Last): Rhodes

4. DATE OF DEATH (Month) (Day) (Year): July 23 1969

5. SEX: Fe
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 5
8. DATE OF BIRTH: Aug 31 1938
9. AGE (In years last birthday): 30 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frederick Meurer — BIRTHPLACE: France
14. MOTHER'S MAIDEN NAME: Eileen Olive Seely — BIRTHPLACE: New Jersey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 158 28 9999
17. INFORMANT'S OWN SIGNATURE: Robert W. Rhodes — ADDRESS: 841 S/123rd Omaha Neb.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumothorax — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Crushed Chest — minutes
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: None Pr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Forest 12
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Near Lamb Creek Bonner 090 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 23 69 4:00 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Slipped under moving vehicle

22. *I hereby certify that I attended the deceased from* DOA, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Arthur Evans MD 162
23b. ADDRESS: Newport, Wn
23c. DATE SIGNED: 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Remova 13
24b. DATE: 7/23/69
24c. NAME OF CEMETERY OR CREMATORY: Sherman Funeral Home
24d. LOCATION (City, town, or county) (State): Newport, Wash.

DATE REC'D BY LOCAL REG.: 8/4/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: C. E. Sherman
LICENSE NO.: QL155

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sherman Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3142
Local Reg. No. #74
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 6 1969 Bureau of Vital

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 3 days 303
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 331 S. Lavina

3. NAME OF DECEASED (Type or Print)
a. (First): Nellie
b. (Middle): Olive
c. (Last): Goulette

4. DATE OF DEATH (Month) (Day) (Year): July 27, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 15, 1892
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Simon A. Blair — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Lucy Collison — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0--------
16. SOCIAL SECURITY NO.: 518 01 7990 D
17. INFORMANT'S OWN SIGNATURE: Beth E. Goulette Sr. — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2041

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic lymphocytic leukemia — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 24, 1969, *to* July 27, 1969, *that I last saw the deceased alive on* July 27, 1969, *and that death occurred at* 8:56p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Helen E. Peterson 415 M.D. 1
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 8/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Lakeview Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 8/5/69
REGISTRAR'S SIGNATURE: Dale Pederson
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3143
Local Reg. No. 249
Reg. Dist. No. 610

RECEIVED AUG - 5 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) Months 900
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1604 Juniper Drive 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls 101
d. STREET ADDRESS (If rural, give location) 1604 Juniper Drive

3. NAME OF DECEASED (Type or Print) a. (First) Cecil b. (Middle) Ivan c. (Last) Hansen

4. DATE OF DEATH (Month) May (Day) 22 (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH September 28, 1910

9. AGE (In years last birthday) 58
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Taylor, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lawrence A. Hansen
BIRTHPLACE Idaho

14. MOTHER'S MAIDEN NAME Kathy Humphrey
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2
(If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO. 519 10 1261

17. INFORMANT'S OWN SIGNATURE Lynn K. Hansen
ADDRESS Idaho Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

535X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Anemia Severe — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gastritis — 3 mths
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gout Cerebral atrophy

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Idaho Falls Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1967, to May, 1969, that I last saw the deceased alive on 5-20, 1969, and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE P L Hansen MD (Degree or title)

23b. ADDRESS FARREL L. HANSEN, M.D. 502 CLEVELAND ST. IDAHO FALLS, IDAHO 83401 PH. 523-0375

23c. DATE SIGNED 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 5/26/69

24c. NAME OF CEMETERY OR CREMATORY Iona Cemetery

24d. LOCATION (City, town, or county) Iona (State) Idaho

DATE REC'D BY LOCAL REG. July 31, 1969

REGISTRAR'S SIGNATURE Anna Rudges

25. EMBALMER Ralph M. Wood Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3144
Local Reg. No. 209
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 13 1969 Bureau

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 93
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 461 Maple Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	AMY	CHRISTINA	GUSTAFSON	June 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Oct. 23, 1878	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Butterfield, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gustof Johnson,	Sweden	Christina Anselm	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	519 60 6030 JI	Mrs. Nora Clark (by Phone)	Rexburg, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 101 (COUNTY) (STATE)
		IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-30-, 19 67, *to* 6-22-69, 19, *that I last saw the deceased alive on* 6-17, 19 69, *and that death occurred at* 3:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. A. [illegible] 294	IDAHO FALLS, IDAHO 83401	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	June 22, 69	Moscow Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 4-69	Anna Rudgren	[signature]	E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3145
Local Reg. No. 237
Reg. Dist. No. 610

RECEIVED JUL 29 1969

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 2065 Dove Dr. Ida. Falls, Ida.
d. STREET ADDRESS (If rural, give location): 2065 Dove Dr.

3. NAME OF DECEASED (Type or Print)
a. (First): ELLA
b. (Middle): LOUISE
c. (Last): DEEDE

4. DATE OF DEATH (Month) (Day) (Year): July 1, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 29, 1911
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Hamburg, Germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Otto Bolzmann, BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Emma Eggert, BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Hans Deede — ADDRESS: Ida. Falls, I

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 wks.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Carcinoma - left breast — 8 wks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* metastatic CA of stomach, Rheumatoid arthritis, diabetes — 5 yrs

19a. DATE OF OPERATION: 5-23-69
19b. MAJOR FINDINGS OF OPERATION: Carcinoma - left breast
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls 101 Bonneville, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-22-, 1969, *to* 7-1, 1969, *that I last saw the deceased alive on* 7-1, 1969, *and that death occurred at* 6:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M Fetton 515 Md 1
23b. ADDRESS: 1555 So Blvd Idaho Falls
23c. DATE SIGNED: 7-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 3, 69
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: July 24-69
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Bill Sullivan
LICENSE NO.: E387

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3146
Local Reg. No. 232
Reg. Dist. No. 670

BIRTH NO.

JUL 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 4 days 3 04
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 0 1/2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 123 East 22nd Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alice		Redman	July 2 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	August 17, 1877	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Lehi, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elisha Peck	England	Charlotte Russon	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2 / 0	Not Available	Dorothy Goates by R M Wood	Idaho Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 3 wks.
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Secondary anemia, due to hematuria, cause undetermined

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 101 (COUNTY) (STATE)
		Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-3, 1969 *to* 7-2, 1969, *that I last saw the deceased alive on* 7-2, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X O. Blair MD 156	Idaho Falls, Idaho	7-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7/2/69	Lehi Cemetery	Lehi Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 16-'69		Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 9 1970
AUG 4 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

State File No. 3147
Local Reg. No. 226
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY BONNEVILLE 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 101 IDAHO FALLS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. HOSPITAL 042	d. STREET ADDRESS (If rural, give location) 599½ H St.

3. NAME OF DECEASED (Type or Print)	a. (First) ASA	b. (Middle)	c. (Last) BAIRD	4. DATE OF DEATH (Month) (Day) (Year) July 3, 1969
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3	8. DATE OF BIRTH 24 May 1880	9. AGE (In years last birthday) 89 — IF UNDER 1 YR. Months 1 Days 9 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer 04	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Centerville, Utah	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Hyrum Baird	BIRTHPLACE Quincy, Illinois	14. MOTHER'S MAIDEN NAME Fanny E. Sessions	BIRTHPLACE Bountiful, Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Clair K Baird	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Causes incidental age — INTERVAL BETWEEN ONSET AND DEATH Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Probable Small Stroke

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on* July 3, *19*69 *, and that death occurred at* 4 A.M. *, from the causes and on the date stated above.*

23a. SIGNATURE Harvey A. Hatch (Degree or title) MD 1	23b. ADDRESS Idaho Falls, Idaho	23c. DATE SIGNED July 8, 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7 July 1969	24c. NAME OF CEMETERY OR CREMATORY Firth Cemetery	24d. LOCATION (City, town, or county) (State) Firth, Idaho
DATE REC'D BY LOCAL REG. July 10-'69	REGISTRAR'S SIGNATURE Anna Bridgee	25. EMBALMER Leo A. Williams	LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3148
Local Reg. No. 227
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 1 day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ARTHUR
b. (Middle): EDGAR
c. (Last): HEZEL

4. DATE OF DEATH (Month) (Day) (Year): July 3, 1969

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: 21 Oct 1898
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Engineer 21
10b. KIND OF BUSINESS OR INDUSTRY: Bell Telephone
11. BIRTHPLACE (State or foreign country): Eureka, South Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Hezel
BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Anna Maag
BIRTHPLACE: Yankton, South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 540-03-3567
17. INFORMANT'S OWN SIGNATURE: X Harold T. Hezel
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Organic heart disease — 15 yrs.
DUE TO (c) Arteriosclerosis — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Sigmoid volvulus, Bilating hernia — 2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Closed-loop large bowel obstruction
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls 101 Bonneville Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-3, 1969, *to* 7-3, 1969, *that I last saw the deceased alive on* 7-3, 1969, *and that death occurred at* 3:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. Sutton 515 M.D. 1
23b. ADDRESS: 1555 So Blvd Idaho Falls Idaho
23c. DATE SIGNED: 7/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7 July 69
24c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
24d. LOCATION (City, town, or county) (State): St. Anthony, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 7-12-'69
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: M. D. Hansen — M. D. Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 12 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-6788
BIRTH NO.

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3149
Local Reg. No. 229
Reg. Dist. No. 616

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 3 hrs. 40
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 529 11th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES	*	PHILLIPP	July 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	July 3, 1969				3	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 00	None	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Phillipp	Ida. Falls, Ida	Bernice Wille	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	None	Herman J Phillipp	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anoxia — (Interval between onset and death) 00

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atrophic placentae
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clark E. Carey	MD	Idaho Falls, Ida	7/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 5, 1969	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 12-69	Irma Rudge	Buck-Sullivan	E 387

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 23 1969 Bureau of Vital Statistics

State File No. 3150
Local Reg. No. 233
Reg. Dist. No. 610

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 14 days 3/4
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1000 Taylor Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Adrian; b. (Middle) Alfred; c. (Last) Merrill

4. DATE OF DEATH (Month) July (Day) 5 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married B

8. DATE OF BIRTH: December 12, 1890

9. AGE (In years last birthday): 78
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney 16

10b. KIND OF BUSINESS OR INDUSTRY: Law

11. BIRTHPLACE (State or foreign country): Richmond, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alma Merrill
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Rebecca Hendricks
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): C

16. SOCIAL SECURITY NO.: 518 50 6800

17. INFORMANT'S OWN SIGNATURE: Ralph C. Merrill
ADDRESS: Sacramento, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 4-13-, 1967, *to* 7-5, 1969, *that I last saw the deceased alive on* 7-4-, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: John S. McMullin 348 (Degree or title) MD
23b. ADDRESS: 550 4th Street
23c. DATE SIGNED: 7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/9/69
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county): Idaho Falls
(State): Idaho

DATE REC'D BY LOCAL REG.: July 16-1969
REGISTRAR'S SIGNATURE: Lena Rudger

25. EMBALMER: Ralph M. Wood Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3151
Local Reg. No. 238
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JUL 29 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 2 days 302
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) 418 East Main

3. NAME OF DECEASED (Type or Print) a. (First) EVELYN b. (Middle) PETERSON c. (Last) LITTON

4. DATE OF DEATH (Month) (Day) (Year) July 6, 1969

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 18 April 1902
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 31
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Worth, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Otto Peterson BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME McRenolds BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. 2
(If yes, give war or dates of service) 8
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE John C Litton ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-4, 1969, to 7/6, 1969, that I last saw the deceased alive on 7/6, 1969, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE [signature] (Degree or title) M
23b. ADDRESS Idaho Falls. Idaho
23c. DATE SIGNED 7/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10 July 69
24c. NAME OF CEMETERY OR CREMATORY Pineview Cemetery
24d. LOCATION (City, town, or county) (State) Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG. July 29-69
REGISTRAR'S SIGNATURE Anna Rudges
25. EMBALMER M. D. Hansen [signature]
LICENSE NO. E-354
FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 14 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 29 1969

Certificate of Death

STATE OF IDAHO

State File No. 3152
Local Reg. No. 248
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write Bureau and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 142 1st St.

3. NAME OF DECEASED (Type or Print): a. (First) GIUSSEPPE b. (Middle) JOE c. (Last) MAURO

4. DATE OF DEATH (Month) (Day) (Year): July 7, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 2

8. DATE OF BIRTH: Jan 16, 1897

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motel Manager 26

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Crucoli, Italy

12. CITIZEN OF WHAT COUNTRY?: Italy

13. FATHER'S NAME: Giovanni Mauro,
BIRTHPLACE: Italy

14. MOTHER'S MAIDEN NAME: Maria Anselmo,
BIRTHPLACE: Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 2 C

16. SOCIAL SECURITY NO.: 519 20 4701

17. INFORMANT'S OWN SIGNATURE: Mrs. Joe Mauro
ADDRESS: Ida. Falls,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage
INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: diabetes mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M D

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 10, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cmetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: July 24-69

REGISTRAR'S SIGNATURE

25. EMBALMER

LICENSE NO.: E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 17 2017

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 29 1969

State File No. 3153
Local Reg. No. 239
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 239 Pinon St. Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS 101
d. STREET ADDRESS (If rural, give location) 239 Pinon St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
REID	EVANS	LEWIS	July 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married 3	8 Sept 1926	42	10 / 0	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Superintendant 26	Construction	Logan, Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Lewis	Logan, Utah	Virginia Evans	Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0		Mirene H. Lewis	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Failure	Instant
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary Occlusion	?
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hypertension	2yrs.

4100

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7/7, 19 69, *to* 7/8, 19 69, *that I last saw the deceased alive on* 7/7, 19 69, *and that death occurred at* 12 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David N. Smith M.D.	Idaho Falls	7/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/11/69	Fielding Memorial Park	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 22 '69	Anna Bridges	Geo A Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 9 1969

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DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 29 1969 Bureau of Vital Statistics

State File No. 3154
Local Reg. No. 246
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
c. LENGTH OF STAY (in this place) LIFE 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. HOSPITAL 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDADHO FALLLS 101
d. STREET ADDRESS (If rural, give location) 430 Cliff St,

3. NAME OF DECEASED (Type or Print) a. (First) MINNIE b. (Middle) c. (Last) MARKER

4. DATE OF DEATH (Month) (Day) (Year) July 8, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) O

8. DATE OF BIRTH March 13, 1891

9. AGE (In years last birthday) 78

IF UNDER 1 YR. Months 3 Days 22

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saleswoman 24

10b. KIND OF BUSINESS OR INDUSTRY Drug Store

11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Alma Marker BIRTHPLACE Manti, Utah

14. MOTHER'S MAIDEN NAME Elizabeth Larson BIRTHPLACE Manti, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Almira Saddler ADDRESS El Paso Texas

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

201X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-7 , 1967 *to* 7/8 , 1969 *, that I last saw the deceased alive on* 7/8 , 1969 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 5/6/69

23b. ADDRESS Idaho Falls, Ida

23c. DATE SIGNED 7/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 12, 1969

24c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery

24d. LOCATION (City, town, or county) (State) Idaho Falls Idaho

DATE REC'D BY LOCAL REG. July 26-69

REGISTRAR'S SIGNATURE Lena Budge

25. EMBALMER Geo A. Williams

LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH--63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 18 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3155
Local Reg. No. 235
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JUL 23 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 month 20
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Extended care 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Milo 101
d. STREET ADDRESS (If rural, give location): Rte. #1 Idaho Falls

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE b. (Middle) ARTHUR c. (Last) WILMOT

4. DATE OF DEATH (Month) (Day) (Year): July 8, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 20, 1881

9. AGE (In years last birthday): 87 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Charles City, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alonzo Nelson Wilmot — BIRTHPLACE: x

14. MOTHER'S MAIDEN NAME: Eliza Jane Butterfield — BIRTHPLACE: x

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-22-0297

17. INFORMANT'S OWN SIGNATURE: Don Wilmot — ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonitus (Bilateral) — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Anterior Coronary Heart Disease — 10 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-30, 1951, *to* July 8, 1969, *that I last saw the deceased alive on* July 8, 1969, *and that death occurred at* 8:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: July 11, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 11, 1969

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: July 17-1969

REGISTRAR'S SIGNATURE

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-630 (2)

DUTIES:

OCT 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 4 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3156
Local Reg. No. 236
Reg. Dist. No. 611

BIRTH NO.

JUL 23 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville /01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN (this place): Minutes 500
d. FULL NAME OF HOSPITAL OR INSTITUTION: Route # 1 (Farm Accident) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Iona /01
d. STREET ADDRESS (If rural, give location): 143 S. 1st

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bradley	J.	Armstrong	July	9	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married /	July 13, 1955	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	Jr. High School	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dee L. Armstrong	Idaho	Erma Burke	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 3	0	None	Dee L. Armstrong	Iona, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 928X Crushed Skull

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE 1 (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Farm 04

21c. (CITY, TOWN, OR TOWNSHIP) Iona 13 (COUNTY) Bonneville 101 (STATE) Idaho

21d. TIME OF INJURY (Month) 7 (Day) 9 (Year) 69 (Hour) 7:00 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? tractor tipped over

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Vernal Bydalek (Degree or title) Coroner

23b. ADDRESS: 3824 E. 17th Idaho Falls Idaho

23c. DATE SIGNED: 7-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial /	7/12/69	Iona Cemetery	Iona Bonneville Co. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 19-'69	Leona Bridger	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3157
Local Reg. No. 241
Reg. Dist. No. 610

BIRTH NO.

JUL 29 1969
Bureau of Vital

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 1 month 201	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location): 375 Tendoy

3. NAME OF DECEASED (Type or Print)	a. (First): Edward	b. (Middle): F.	c. (Last): Clements	4. DATE OF DEATH (Month) July (Day) 10 (Year) 1969		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: June 16, 1901	9. AGE (In years last birthday): 68	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banker 25	10b. KIND OF BUSINESS OR INDUSTRY: Banking	11. BIRTHPLACE (State or foreign country): Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Edward M. Clements	BIRTHPLACE: Oregon	14. MOTHER'S MAIDEN NAME: Elisa Lenior	BIRTHPLACE: Switzerland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1	(If yes, give war or dates of service): 3 WW 1	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Edward M. Clements	ADDRESS: 375 TENDOY		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4419

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Ruptured aortic aneurysm	Acute
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arterio sclerosis	Years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hypertension	Years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-25, 1968, *to* 7/10, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 546 (Degree or title) 1	23b. ADDRESS: Idaho Falls, Idaho	23c. DATE SIGNED: 7/18/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: 7/12/69	24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	24d. LOCATION (City, town, or county): Idaho Falls (State): Idaho
DATE REC'D BY LOCAL REG.: July 22 - 69	REGISTRAR'S SIGNATURE: [signature]	25. EMBALMER: Ralph M. Wood [signature]	LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3158
Local Reg. No. 242
Reg. Dist. No. 6/0

RECEIVED JUL 29 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY in this place: 1 month 28
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Good Samaritan Rest Home

3. NAME OF DECEASED (Type or Print): a. (First) VERVA b. (Middle) NELL c. (Last) JONES

4. DATE OF DEATH (Month) (Day) (Year): July 11, 69

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 11, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator,

10b. KIND OF BUSINESS OR INDUSTRY: Bell System

11. BIRTHPLACE (State or foreign country): Adel, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Loper 04

BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Hoeye,

BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 575 10 5770

17. INFORMANT'S OWN SIGNATURE: Thelma P Jones
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hip Fracture

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Nursing Home

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Pt fell

22. *I hereby certify that I attended the deceased from* 7 July, 1969, *to* 11 July, 1969, *that I last saw the deceased alive on* 11 July, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Charles R Boge 653 (Degree or title) MD

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-14-69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: July 22 69

REGISTRAR'S SIGNATURE: Anne Bridges

25. EMBALMER: Dick Sullivan

LICENSE NO.: E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302A

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 26 196

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3159
Local Reg. No. 234
Reg. Dist. No. 610

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JOHANNA
b. (Middle): BAUERLE
c. (Last): PETERSON

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 29, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): z Oberstenfeld Germany
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Wilhelm Bauerle — BIRTHPLACE: Oberstenfeld Germany
14. MOTHER'S MAIDEN NAME: Kathrina Susanna Knapp — BIRTHPLACE: Walklinsweiler, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 0 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-03-8559 D
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: 4068 North Lake Drive, Milwaukee, Wis. 53211

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/24, 1969, *to* 7/12, 1969, *that I last saw the deceased alive on* 6-4, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Asael Tall, 522 M.D. (Degree or title)
23b. ADDRESS: Rigby, Idaho
23c. DATE SIGNED: 7/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/16/69
24c. NAME OF CEMETERY OR CREMATORY: Sugar City
24d. LOCATION (City, town, or county) (State): Sugar City Madison Idaho

DATE REC'D BY LOCAL REG.: July 15-69
REGISTRAR'S SIGNATURE: Anna Bredger
25. EMBALMER: Russel Flamm — LICENSE NO.: E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 2 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3160
Local Reg. No. 251
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG - 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY IN (this place) 4 days 304
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls 101
d. STREET ADDRESS (If rural, give location) 695 Lomax Street

3. NAME OF DECEASED (Type or Print) a. (First) May b. (Middle) c. (Last) Winther
4. DATE OF DEATH (Month) July (Day) 12 (Year) 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 1, 1900
9. AGE (In years last birthday) 69
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Paradise, Utah
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Howells BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Sarah James BIRTHPLACE Utah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 519 07 4878
17. INFORMANT'S OWN SIGNATURE Adelst Winther ADDRESS Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1830

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer of ovary — INTERVAL BETWEEN ONSET AND DEATH 10 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Aug 23, 1968
19b. MAJOR FINDINGS OF OPERATION Ovary - (?) Metastatic Carcinoma Secondary Ca of Bowel -
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Harvey A. Hatch 208 (Degree or title) MD
23b. ADDRESS Idaho Falls Idaho
23c. DATE SIGNED July 28, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/17/69
24c. NAME OF CEMETERY OR CREMATORY Wasatch Cemetery
24d. LOCATION (City, town, or county) Salt Lake City (State) Utah

DATE REC'D BY LOCAL REG. July 31, 1969
REGISTRAR'S SIGNATURE Anna Rudger
25. EMBALMER Ralph M. Wood
LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3161
Local Reg. No. 244
Reg. Dist. No. 6/0

RECEIVED JUL 29 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (Inside City Limits)
b. CITY OR TOWN: Idaho Falls
c. LENGTH OF STAY (in this place): 1 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: 374 1/2 K street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN: Idaho Falls
d. STREET ADDRESS (If rural, give location): 374 1/2 K street

3. NAME OF DECEASED (Type or Print): a. (First) REBECCA b. (Middle) MARILLA c. (Last) AMES

4. DATE OF DEATH (Month) (Day) (Year): July 15, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 2, 1894

9. AGE (In years last birthday): 75 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Spring glen, Utah.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew Jackson Simmons — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Agnes Elizabeth Bellows — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-60-1735

17. INFORMANT'S OWN SIGNATURE: Wm E. Galbraith — ADDRESS: Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4272

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): "Causes incident to age"
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19—, *to* July 15, 1969, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 5:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. J. Buchanan 044 (Degree or title): M.D.
23b. ADDRESS: Idaho Falls, Idaho.
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 18, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sutton Cemetery
24d. LOCATION (City, town, or county) (State): Archer Madison Idaho

DATE REC'D BY LOCAL REG.: July 29-69
REGISTRAR'S SIGNATURE: Anna Rudges
25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404
FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-7286
BIRTH NO.

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3162
Local Reg. No. 245
Reg. Dist. No. 610

JUL 2 1969

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): Min 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby 260
d. STREET ADDRESS (If rural, give location): 183 East 1st North

3. NAME OF DECEASED (Type or Print): a. (First) LYNDA b. (Middle) LEA c. (Last) WILSON

4. DATE OF DEATH (Month) (Day) (Year): July 16, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: July 15, 1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days: 1 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Rexburg, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Lee Wilson — BIRTHPLACE: Texas

14. MOTHER'S MAIDEN NAME: Judith Jill Arnell — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): 0 None

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: W L Wilson — ADDRESS: Rigby, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hyaline Membrane Disease 7761

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Patent Ductus Arteriosus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-15, 1969, *to* 7-16, 1969, *that I last saw the deceased alive on* 7-16, 1969, *and that death occurred at* 4:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Lester J Peterson III (Degree or title): M.D.

23b. ADDRESS: Rexburg, Idaho.

23c. DATE SIGNED: 7-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Little Butte

24d. LOCATION (City, town, or county) (State): Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.: July 22, '69

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Bruce A. Eckersell LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3163
Local Reg. No. 25
Reg. Dist. No. 6/0

RECEIVED
AUG - 5 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 10
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 302 East 17th

3. NAME OF DECEASED (Type or Print): a. (First) REESE b. (Middle) CARLYLE c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year): July 18, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Oct. 26, 1914

9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Arthur B. Johnson — BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Helen Pelot — BIRTHPLACE: Idaho Falls, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No 2 / 0

16. SOCIAL SECURITY NO.: 516 22 9504

17. INFORMANT'S OWN SIGNATURE: Scott R. Johnson — ADDRESS: IF, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

15-79

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma of the pancreas — INTERVAL BETWEEN ONSET AND DEATH: 7 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* March 1, 1969, *to* July 18, 1969, *that I last saw the deceased alive on* July 18, 1969, *and that death occurred at* 12:00 M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Bryan T. Weeks MD

23b. ADDRESS: 1585 So. Boulevard

23c. DATE SIGNED: July 25, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 14, 69

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Cem.

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Aug. 1 1969

REGISTRAR'S SIGNATURE: Anne Bridges

25. EMBALMER: Bruce Sullivan

LICENSE NO.: E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3164
Local Reg. No. 254
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 13 1969 Statistics

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE /01/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS Burg
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. HOSPITAL 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: BONNEVILLE /01/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): GEN DEL.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ENOCH	E.	HALE	July 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	DIVORCED 2	March 3, 1915	54	4	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 06		Hailey, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Enoch L. Hale	Missouri	Cynthia Davy	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0		Mrs Frances Scott.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 486X Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 15, 1969 *to* July 19, 1969, *that I last saw the deceased alive on* July 19, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron T. Weeks MD	1585 So. Boulevard	July 31, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July22, 1961	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 6-1969	Anna Bridges	Leo A Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 0 7 1996

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3165
Local Reg. No. 248
Reg. Dist. No. 610

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 AUG 19 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 377 1st. St.

3. NAME OF DECEASED (Type or Print)
a. (First): JIMMIE
b. (Middle): ADELINE
c. (Last): SNYDER

4. DATE OF DEATH (Month) (Day) (Year): July 20, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 2, 1912
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): West Point, Mississippi
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Nanney — BIRTHPLACE: Unk.
14. MOTHER'S MAIDEN NAME: Pear Unk. — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT'S OWN SIGNATURE: Wilbur M. Snyder — ADDRESS: IF

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Renal shutdown — 7 days
DUE TO (c): Cardiac decompensation & failure — Several weeks

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Asthma - Emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb., 1961, *to* July 20, 1969, *that I last saw the deceased alive on* July 20, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): T. J. Bingham 044 Mid.
23b. ADDRESS: Idaho Falls Idaho
23c. DATE SIGNED: Aug. 8 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 23, 1969
24c. NAME OF CEMETERY OR CREMATORY: Nampa Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Aug. 14-69
REGISTRAR'S SIGNATURE: Anna Bridger
25. EMBALMER: Bill Sullivan
LICENSE NO.: E 387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 5 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3166
Local Reg. No. 253
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG - 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (In this place): 4 days 304
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): Route # 2 Box 67

3. NAME OF DECEASED (Type or Print): a. (First) Elmer; b. (Middle); c. (Last) Moedl
4. DATE OF DEATH: (Month) July (Day) 21 (Year) 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 8, 1910
9. AGE (In years last birthday): 59 IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher & Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Cattle & Farming
11. BIRTHPLACE (State or foreign country): Grant, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Xaver Moedl BIRTHPLACE: USA
14. MOTHER'S MAIDEN NAME: Katherine BIRTHPLACE: USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO.: Not Available
17. INFORMANT'S OWN SIGNATURE: Ida Moedl ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4309

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Brain stem injury — INTERVAL BETWEEN ONSET AND DEATH: 29 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Sub arachnoid hemorrhage — 29 days
DUE TO (c) intra cranial aneurysm

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18- , 1969 , *to* 7-27- , 19 69 , *that I last saw the deceased alive on* 7-27- , 1969 , *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE: George W Barnard MD (Degree or title)
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 7-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/25/69
24c. NAME OF CEMETERY OR CREMATORY: Grant Central Cemetery
24d. LOCATION (City, town, or county) (State): Grant Jefferson Co. Idaho

DATE REC'D BY LOCAL REG.: July 30, 1969
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 7 1969

MAY 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

AUG 1 3 2008

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....An autopsy indicated a aneurysm at junction of left internal carotid artery and posterior communicating artery of the brain; a massive embolism of the pulmonary arteries was also found.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 29 1969

Certificate of Death

STATE OF IDAHO

State File No. 3167
Local Reg. No. 247
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1256 St. Clair

3. NAME OF DECEASED (Type or Print): a. (First) KENNETH b. (Middle) JESSE c. (Last) QUINONES

4. DATE OF DEATH (Month) (Day) (Year): July 23, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 15, 1938

9. AGE (In years last birthday): 31 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpet Layer 06

10b. KIND OF BUSINESS OR INDUSTRY: Carpet

11. BIRTHPLACE (State or foreign country): Ogden, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Quinones — BIRTHPLACE: Mexico

14. MOTHER'S MAIDEN NAME: Julia Grahan — BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): none 8

16. SOCIAL SECURITY NO.: 530-24-0780

17. INFORMANT'S OWN SIGNATURE: Kathy A. Quinones — ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 22663 Sinealoma — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES X NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19 67, *to* July 23, 19 67, *that I last saw the deceased alive on* July 23, 19 69, *and that death occurred at* 3:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Bruce A. Eckersell (Degree or title) M.D.

23b. ADDRESS: 798 So. Blvd. Idaho Falls, Idaho.

23c. DATE SIGNED: 7.25.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 28, 1969

24c. NAME OF CEMETERY OR CREMATORY: Reno

24d. LOCATION (City, town, or county) (State): Reno, Nevada.

DATE REC'D BY LOCAL REG.: July 26-69

REGISTRAR'S SIGNATURE: Anna Rudges

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: FEB 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-6851

BIRTH NO.

RECEIVED AUG 13 1969 Bureau

Certificate of Death

STATE OF IDAHO

State File No. 3168
Local Reg. No. 255
Reg. Dist. No. 610

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho Falls LDS Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idahp
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JOELL
b. (Middle):
c. (Last): DAVIS

4. DATE OF DEATH (Month) (Day) (Year): July 25, 1969

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 24, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 9 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Randy Davis
BIRTHPLACE: Youngstown, Ohio
14. MOTHER'S MAIDEN NAME: Cheryle Nagle
BIRTHPLACE: St. Anthony, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 2 (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Rand D. Davis
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 96 hr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24, 1969, *to* 7-25, 1969, *that I last saw the deceased alive on* 7-25, 1969, *and that death occurred at* 3:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. Wm Bridges 638 NO 1
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 28th July 69
24c. NAME OF CEMETERY OR CREMATORY: Parker Cemetery
24d. LOCATION (City, town, or county) (State): Parker, Idaho

DATE REC'D BY LOCAL REG.: Aug 6-69
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: M. D. Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 13 1969 Bureau of Vital Statistics

State File No. 3169
Local Reg. No. 159
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 day 39
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 045

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 1225 Ada

3. NAME OF DECEASED (Type or Print): a. (First) Peggy; b. (Middle) Marie; c. (Last) Peterson

4. DATE OF DEATH: (Month) July (Day) 25 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: February 28, 1944

9. AGE (In years last birthday): 25
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Los Angeles, California

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William McBride DeWitt
BIRTHPLACE: California

14. MOTHER'S MAIDEN NAME: Dorothy White
BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 521 56 9794

17. INFORMANT'S OWN SIGNATURE: Peggy A. Peterson
ADDRESS: Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

481X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Bacterial Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 60 hrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Diplococcus pneumoniae
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 23, 19 69, *to* July 25, 19 69, *that I last saw the deceased alive on* July 25, 19 69, *and that death occurred at* 10:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE: Philip D. Affleck (Degree or title) MD
23b. ADDRESS: 2065 E. 17th. St,
23c. DATE SIGNED: 8,1,69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/29/69
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county): Idaho Falls (State): Idaho

DATE REC'D BY LOCAL REG.: Aug. 7-1969
REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Ralph M. Wood Ralph M. Wood
LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 10 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3170
Local Reg. No. 234
Reg. Dist. No. 610

RECEIVED AUG 13 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 weeks 4/4
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho Falls LDS Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 22
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): b630 East 4th North

3. NAME OF DECEASED (Type or Print)
a. (First): SAMUEL
b. (Middle): SCHWENDIMAN
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): July 25, 1969

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Oct., 8, 1864

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 94

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cattleman and Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (State or foreign country): Oberstoken, Switzerland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Schwendiman
BIRTHPLACE: Switzerland

14. MOTHER'S MAIDEN NAME: Magdalena Stradhaur
BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 519-42-9746

17. INFORMANT'S OWN SIGNATURE: Earl Schwendeman
ADDRESS: Newdale, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardeal infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-25-, 1969, *to* 7-25, 1969, *that I last saw the deceased alive on* July 24, 1969, *and that death occurred at* 1:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John A Schwendiman M.D.

23b. ADDRESS: 550 4th Street

23c. DATE SIGNED: 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 28th Juky 69

24c. NAME OF CEMETERY OR CREMATORY: Teton-Newdale Cemetery

24d. LOCATION (City, town, or county) (State): Sugar City, RFD, Idaho

DATE REC'D BY LOCAL REG.: Aug 5-1969

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: M. D. Hansen
LICENSE NO.: E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3171
Local Reg. No. 256
Reg. Dist. No. 610

RECEIVED AUG 13 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 50 years / 50
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 220 E. 17th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BESSIE	LORENE Merrill	MULCAHY	July 26 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced 3	August 5, 1904	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	Own Home	Sac County, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John M. Hartert	Iowa	Blanche Chartier	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes / World War II	519-09-2555	Lorene Merrill	Ogden, Utah

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — 4310 — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Hypertension — Many yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-14 *19* 67, *to* 7-26- *, 19* 69, *that I last saw the deceased alive on* 7/26 *, 19* 69, *and that death occurred at* 3:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. D.	Idaho Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 29, 1969	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 4. 1969	Anne Burgess	Orland C. Buck	250-E

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

DUTIES:

AUG 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 13 1969 Bureau of Vital Statistics

State File No. 3172
Local Reg. No. 260
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 day 30/
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 1315 Elmore

3. NAME OF DECEASED (Type or Print): a. (First) Arthur; b. (Middle) John; c. (Last) Lake

4. DATE OF DEATH: (Month) July (Day) 29 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 8, 1940

9. AGE (In years last birthday): 29
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Potatoes & City

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ernest Lake Sr. BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Violet Mathilda Peterson BIRTHPLACE: Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: not available

17. INFORMANT'S OWN SIGNATURE: * Dorothy Lake ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION — 5330

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Peritonitis — 1 day
DUE TO (c): Perforated peptic ulcer — 1 day

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 29 *, 19*69*, to* July 29 *, 19*69*, that I last saw the deceased alive on* July 29 *, 19*69*, and that death occurred at* 12:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David H. Smith M.D.

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 8/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/1/69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Aug. 7-1969

REGISTRAR'S SIGNATURE: Emma Briggs

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3173
Local Reg. No. 265
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
AUG 19 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pincrest Golf Coarse 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1149 Woodruff

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): *
c. (Last): ANDERSON

4. DATE OF DEATH: (Month) (Day) (Year): July 30, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 2

8. DATE OF BIRTH: Nov. 30, 1909

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construcion 11

10b. KIND OF BUSINESS OR INDUSTRY: Mnt. St. Telephone

11. BIRTHPLACE (State or foreign country): Council, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Aaron Anderson,
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Mary Winkler
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes / (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 519 01 0497

17. INFORMANT'S OWN SIGNATURE: Mrs George Anderson
ADDRESS: IF,I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

94189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [4] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. H. Baker 018 (Degree or title) M.D.
23b. ADDRESS: Idaho Falls, Ida
23c. DATE SIGNED: 8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 2, 69
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Aug. 11-1969
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Bill Sullivan
LICENSE NO.: E - 387

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 1 0 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 2 2 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 13 1969 Bureau of

State File No. 3174
Local Reg. No. 257
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): DOA .000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 2597 Sunnyside Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Myrtle	V.	Buttars	July 30 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	July 11, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Goshen, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Andrew Carter	Utah	Maude Gardner	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2 / 0	518 44 2622	James L Buttars	Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Heart Disease 4109 — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1946 *to* 30 July, 1969, *that I last saw the deceased alive on* 30 July, 1969 *and that death occurred at* 7:30a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Joseph M Hatch MD	Idaho Falls Idaho	8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/2/69	Ammon Cemetery	Ammon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 5-1969	Anna Bridges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 13 1969 Bureau of Vital Statistics

State File No. 3175
Local Reg. No. 267
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): Years 00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2664 Ammon Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 2664 Ammon Road

3. NAME OF DECEASED (Type or Print): a. (First) Cleo; b. (Middle); c. (Last) Stout
4. DATE OF DEATH: (Month) July (Day) 30 (Year) 1969
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 14, 1908
9. AGE (In years last birthday): 61
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PBX Operator & Secretary
10b. KIND OF BUSINESS OR INDUSTRY: LDS Hospital
11. BIRTHPLACE (State or foreign country): Ammon, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Anderson
BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: May Christensen
BIRTHPLACE: Denmark
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO.: 519 10 7596
17. INFORMANT'S OWN SIGNATURE: Richard D. Black
ADDRESS: Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-5- , 1969 to 7-30 , 1969 , that I last saw the deceased alive on 7-22- , 1969 and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE: John McCullin MD 348 (Degree or title)
23b. ADDRESS: 550 Fourth St
23c. DATE SIGNED: 8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/2/69
24c. NAME OF CEMETERY OR CREMATORY: Ammon Cemetery
24d. LOCATION (City, town, or county) (State): Ammon Idaho

DATE REC'D BY LOCAL REG.: Rec. 9-'69
REGISTRAR'S SIGNATURE: Irma a Budgen
25. EMBALMER: Ralph M. Wood Ralph M. Wood
LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 14 1969
JUN 29 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3176
Local Reg. No. 266
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Sweden, Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): Rural, New Sweden

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) MOSE c. (Last) WATTENBARGER

4. DATE OF DEATH: (Month) (Day) (Year) July 30, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: April 16, 1883

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer, retired 04

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Athens, Tennessee

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Mose Wattenbarger
BIRTHPLACE: Tennessee

14. MOTHER'S MAIDEN NAME: Rebecca Kyker
BIRTHPLACE: Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 519 42 7839

17. INFORMANT'S OWN SIGNATURE: M O. Wattenbarger
ADDRESS: IF, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arterio sclerosis and
ANTECEDENT CAUSES — Arterio sclerotic Heart Disease
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-22, 1968, *to* 7/30, 1969, *that I last saw the deceased alive on* 7/30, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title)

23b. ADDRESS: Idaho Falls, Ida

23c. DATE SIGNED: 8/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 2, 69

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Aug. 11, 69

REGISTRAR'S SIGNATURE: Anna Budge

25. EMBALMER: [signature]

LICENSE NO.: E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3177
Local Reg. No. 269
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 13 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 8 mo. 208
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 330 W. 3rd North

3. NAME OF DECEASED (Type or Print): a. (First) EDWARD b. (Middle) LAURENCE c. (Last) HUNTER

4. DATE OF DEATH (Month) (Day) (Year): July 31, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 29, 1891

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 07

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Lewisville, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward B. Hunter
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Lydia Walker
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-42-9916

17. INFORMANT'S OWN SIGNATURE: Arnold Hunter
ADDRESS: Mill Hallow Dr. Rexburg, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism — 2509
INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — years
DUE TO (c) Diabetes mellitus — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Aug. 1968
19b. MAJOR FINDINGS OF OPERATION: Saphenous vein converted to Artery Rt leg
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 30 May, 1968, *to* 31 July, 1969, *that I last saw the deceased alive on* 30 July, 1969, *and that death occurred at* 4:45a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Hall, M.D. 22 (Degree or title)
23b. ADDRESS: Rigby, Idaho.
23c. DATE SIGNED: 31 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewisville
24d. LOCATION (City, town, or county) (State): Lewisville Jefferson Idaho

DATE REC'D BY LOCAL REG.: Aug. 8 1969
REGISTRAR'S SIGNATURE: Anna Rudgers

25. EMBALMER: Bruce A. Eckersell Bruce A. Eckersell
LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-3021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3178
Local Reg. No. 37-69
Reg. Dist. No. 100

RECEIVED JUL 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 2 days 302
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) Boundary County Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First) THEODORE
b. (Middle) JOSEPH
c. (Last) HELMER

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Dec. 26, 1876

9. AGE (In years last birthday) 92
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner 22

10b. KIND OF BUSINESS OR INDUSTRY Retail Variety

11. BIRTHPLACE (State or foreign country) St. Joseph Missouri

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs V. Helmer
ADDRESS Bonners Ferry, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Recurrent CVA

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967 *to* 7/3, 1969, *that I last saw the deceased alive on* 7/3, 1969, *and that death occurred at* 9 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS Bonners Ferry

23c. DATE SIGNED 7/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/8/69

24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery

24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. July 8, 1969

REGISTRAR'S SIGNATURE

25. EMBALMER

LICENSE NO. E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 19 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3179
Local Reg. No. 38-69
Reg. Dist. No. 100

JUL 30 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
LENGTH OF STAY (in this place): 3 days 3
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): P. O. Box #398

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LUCY	(NMI)	WRIGHT	July 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	November 4, 1897	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 04	Homemaking	Lebanon, Nebraska	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Porter	Pennsylvania	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	703-07-5736B	W Melvin Wright	Spokane, Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible] — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. [illegible] — 3 mos; 20+ yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NO		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
NO		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
NO m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/21, 19[illegible], *to* 7/23, 19[illegible], *that I last saw the deceased alive on* 7/23, 19[illegible], *and that death occurred at* 12:15 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] MD	Bonners Ferry, Ida.	7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/28/69	Grandview Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 28, 1969	Evelyn Stone	Charles O Malone	E-453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

JUN 0 7 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3180
Local Reg. No. 39-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED AUG 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (In this place): 2 years 102
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Restorium 233

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Community Restorium

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): BOYD
c. (Last): STOCKTON

4. DATE OF DEATH (Month) (Day) (Year): July 25, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: November 21, 1904
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Barnardsville, North Carolina
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: William B. Stockton — BIRTHPLACE: North Carolina
14. MOTHER'S MAIDEN NAME: Virginia Belle Burlison — BIRTHPLACE: North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0 ----
16. SOCIAL SECURITY NO.: 539-10-4908
17. INFORMANT'S OWN SIGNATURE: Glen Stockton — ADDRESS: Seattle, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Sclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1966, to 7/25, 1969, that I last saw the deceased alive on 7/25, 1969, and that death occurred at 11 P m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 153 — **23b. ADDRESS**: Bonners Ferry — **23c. DATE SIGNED**: 8/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7/30/69
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: Aug. 13, 1969
REGISTRAR'S SIGNATURE: Twyla Stone
25. EMBALMER: Charles Malone
LICENSE NO.: E-453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3181
Local Reg. No. 1
Reg. Dist. No. 670

RECEIVED JUL 10 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Leslie
c. LENGTH OF STAY IN (Place): 10 mins
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 8 miles N. Leslie (Pass-Creek)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: Alameda
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Alameda
d. STREET ADDRESS (If rural, give location): 1208 Buena Vista Ave.

3. NAME OF DECEASED (Type or Print): a. (First) JOHN; b. (Middle) JOSEPH; c. (Last) HERMAN

4. DATE OF DEATH (Month) (Day) (Year): July 6, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Oct. 4, 1907

9. AGE (In years last birthday): 61 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teamster 27

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Leo P. Herman — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Threse Cossman — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 | (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 564-01-3726

17. INFORMANT'S OWN SIGNATURE: X Mary G. Herman — ADDRESS: Alameda, Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4189

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

Did Not See Alive-Attended as Coroner Only

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 4:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. H. Marvel 583 Butte Co. Coroner

23b. ADDRESS: Arco, Idaho

23c. DATE SIGNED: 7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. Burial

24b. DATE: 7-9-69

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State): (Bay Area) California

DATE REC'D BY LOCAL REG.: July 8-1969

REGISTRAR'S SIGNATURE: Betty J. Marvel

25. EMBALMER: C. H. Marvel — LICENSE NO.: E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3182
Local Reg. No. 347
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 29 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkview Manor 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Lincoln Park

3. NAME OF DECEASED (Type or Print)
a. (First): Burdette
b. (Middle):
c. (Last): Ensign

4. DATE OF DEATH (Month) (Day) (Year): June 17, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Jan. 10, 1879
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Auto mechanic
11. BIRTHPLACE (State or foreign country): Pleasant Valley, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: No Record — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 394-07-9971A
17. INFORMANT'S OWN SIGNATURE: Mrs. Tony Klosterman — ADDRESS: Nampa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Generalized ASHD. — 10 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Hypertrophic Arthritis — 10 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-17, 1960 *to* June 17, 1969, *that I last saw the deceased alive on* June 12, 1969 *and that death occurred at* 7:30P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gryden Olson 115 — **23b. ADDRESS**: Nampa Idaho — **23c. DATE SIGNED**: 24 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county): Canyon County — (State): Idaho

DATE REC'D BY LOCAL REG.: July 28, 1969
REGISTRAR'S SIGNATURE: Irene N. Kante RN
25. EMBALMER: Richard W. Mesenbrink — LICENSE NO.: E-487

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3183
Local Reg. No. 355
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 143
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 17 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital 832

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 172 N. State Street

3. NAME OF DECEASED (Type or Print): a. (First) Gary b. (Middle) Joseph c. (Last) Hutchins

4. DATE OF DEATH (Month) (Day) (Year): June 21, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: 11-18-49
9. AGE (In years last birthday): 20 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Grangeville, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ned M. Hutchins — BIRTHPLACE: Espinola, Washington
14. MOTHER'S MAIDEN NAME: Rosemary Lampoltshame — BIRTHPLACE: Nez Perce, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 5199
17. INFORMANT'S OWN SIGNATURE: Wilma Kesner — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Respiratory Infection — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: mental retardation, Cerebral Palsy.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-15-51, 19___, *to* 6-20-69, 19___, *that I last saw the deceased alive on* 6-20, 1969, *and that death occurred at* 7:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesche M.D 560 (Degree or title): 1
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 7-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6-21-69
24c. NAME OF CEMETERY OR CREMATORY: Kohlerdown Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: July 30, 1969
REGISTRAR'S SIGNATURE:
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 2 2 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 1 6 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3184
Local Reg. No. 357
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 143
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 4 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital 052

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2119 N. 16th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
David	Clair	Matthews	June 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	March 7, 1955	14				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 03		Boise, Idaho	U.S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clair T. Matthews	Idaho	Marie Colson	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 0		Wilma Keyser	Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Laryngospasm — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral palsy — from birth
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

3439

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 12-4-64, 19___, *to* 6-22, 19 69, *that I last saw the deceased alive on* 6-22, 19 69, *and that death occurred at* 3:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
345	Box 47 Nampa	June 25 '69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/26/69	Terrace Lawn Memorial	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 31, 1969	Mrs. Martina Walmsley	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

68-6779

Certificate of Death

STATE OF IDAHO

State File No. 3185
Local Reg. No. 356
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Victoria	Antoinette	Ringenberg	June 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married	July 2, 1968		11	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arnold Dean Ringenberg	Idaho	Sally Long	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 20 0
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Wilma Keyser — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subdural hematomas, chronic — INTERVAL BETWEEN ONSET AND DEATH: 8 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) trauma.
DUE TO (c) Unknown trauma prior to first admission elsewhere.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Acute Respiratory infection — 1 week

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Undet.	home	Twin Falls — Twin Falls, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Unknown m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Unknown

22. I hereby certify that I attended the deceased from 3/20, 1969, to June 29, 1969, that I last saw the deceased alive on June 29, 1969, and that death occurred at 10:15A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert S. McKean M.D.	Nampa, Idaho	7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/2/1969	Twin Falls Cemmetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 30, 1969		Jerry J. Krouse	E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 0 4 2003

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3186
Local Reg. No. 312
Reg. Dist. No. 360

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder, Rt. # 2
c. LENGTH OF STAY (in this place): 0-0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Daughter's Home 0-0

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print)
a. (First): Myla
b. (Middle): Doris
c. (Last): Hargis

4. DATE OF DEATH (Month) (Day) (Year): July 1, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: October 2,1895
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 0
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter Scott Archibald — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Bernice Edna Nye — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 0 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: × Doris Trunnell — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Congestive Heart Failure — 1 wk
DUE TO (c): Atherosclerotic Heart Disease — 10 yr

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased ~~from~~* 6-19, 1969, *to* X, 19X, *that I last saw the deceased alive on* 6-19, 1969, *and that death occurred at* 7 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 876 Der Md
23b. ADDRESS: 222 E Logan Caldwell
23c. DATE SIGNED: 7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Wilder Cemetery
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: July 10, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: James R. Dakan — LICENSE NO. E-485

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended August 29, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3187
Local Reg. No. 319
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (In this place): Days 30C
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2½ Miles E. of Caldwell 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Oregon 38
b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baker
d. STREET ADDRESS (If rural, give location): 1920 Cliff St.

3. NAME OF DECEASED (Type or Print): a. (First) Roger; b. (Middle) Lee; c. (Last) Leary
4. DATE OF DEATH: (Month) July (Day) 1, (Year) 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never
8. DATE OF BIRTH: Jan 5, 1948
9. AGE (In years last birthday): 21; IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy 05
10b. KIND OF BUSINESS OR INDUSTRY: Service
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Roy Leary; BIRTHPLACE: Salt Lake City, Utah
14. MOTHER'S MAIDEN NAME: Beverley Wright; BIRTHPLACE: Salt Lake City, Utah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Viet Nam -Navy
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Roy Michael Leary, ADDRESS: 1920 Cliff, Baker, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Drowning — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto Accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 140 Canyon Idaho
21d. TIME OF INJURY (Month) July (Day) 1, (Year) 1969 (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]
21f. HOW DID INJURY OCCUR? Car ran over bridge & into canal

22. I hereby certify that I attended the deceased from inspection only, 19___, to ___, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at about 2am, from the causes and on the date stated above.

23a. SIGNATURE: Henry C. Wesche, M.D., Coroner (Degree or title) 583 4
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 7-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Elysian Burial Gardens
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: July 10,1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard Flahiff
LICENSE NO.: E 481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 0 9 1995

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED AUG 29 1969 Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Wyoming
County of Natrona } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for Roger Lee Leary (Name on Original Certificate) who died (Was Born or Died) on July 1, 1969 (Date of Event)

in Caldwell, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#14. Mother's Maiden Name	Beverly Carsten	~~Beverly~~ Wright
Mother's Place of birth	not given	Beverley
		Salt Lake City, Utah

Subscribed and sworn to before me this 26th day of August 1969

Phyllis Heatt

Notary Public, residing at Casper, Wyoming

My commission expires April 17, 1972

(Seal)

Signed Beverley Wright

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Wyoming
County of Natrona } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 26th day of August 1969

Phyllis Heatt

Notary Public, residing at Casper, Wyoming

My commission expires April 17, 1972

(Seal)

Signed F. Richard Brown

(Signature of Any Credible Person)

150 North Center - Casper, Wyo.

(Street Address, City, State)

FORM DH 60-155

Rec 17851 6-8-15-67

Certified copy of birth certificate for Roger Lee Leary born January 5, 1948 at Sale Lake City, Utah. Parents names Roy Leary and Beverley Wright. Certified copy issued July 9, 1969. viewed by V.S.

Father and Mother's place of birth is given as Salt Lake City, Utah.

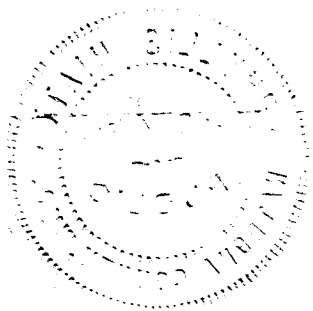

Certificate of Death

State File No. 3187
Local Reg. No. 319
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 11 1969 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN: Rural
c. LENGTH OF STAY (in this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2½ Miles E. of Caldwell

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baker
d. STREET ADDRESS (If rural, give location): 1920 Cliff St.

3. NAME OF DECEASED (Type or Print): a. (First) Roger; b. (Middle) Lee; c. (Last) Leary

4. DATE OF DEATH: (Month) July (Day) 1, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never

8. DATE OF BIRTH: Jan. 5, 1948

9. AGE (In years last birthday): 21
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.Navy

10b. KIND OF BUSINESS OR INDUSTRY: Service

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Roy Leary
BIRTHPLACE: -Salt Lake City

14. MOTHER'S MAIDEN NAME: Beverly Carsten
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Viet Nam- Navy

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Roy Michael Leary
ADDRESS: 1920 Cliff Baker Oregeon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto Accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): High way
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Canyon Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-1-69 ? m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Car Ran Over Bridge & into Canal.

22. *I hereby certify that I attended the deceased from* Inspection Only, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* About 2A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wenk M.D. Coroner.
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 7-9-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Elysian Burial Gardens
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: July 10, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Thomas C. Flaniff
LICENSE NO.: E-481
FIRM NAME: Flaniff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 3 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 29 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 1 _ 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3188
Local Reg. No. 318
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
JUL 11 1969

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2½ Miles E. of Caldwell

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rt. #3 - Middleton 140
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Roy
b. (Middle):
c. (Last): Leary

4. DATE OF DEATH: (Month) July (Day) 1, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Seperated 5

8. DATE OF BIRTH: March 6, 1927

9. AGE (In years last birthday): 42
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Leary
BIRTHPLACE: U.S.A. -unknown

14. MOTHER'S MAIDEN NAME: Pearl Larsen
BIRTHPLACE: U.S.A. -unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW Two 4 Navy 8169

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Roy Michael Leary
ADDRESS: 1920 Cliff St. Baker, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto Accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Broken Neck.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE? (Specify): Accident.

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Canyon 140 Idaho

21d. TIME OF INJURY (Month) 7 (Day) 1 (Year) 69 (Hour) ? m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY Ooccur?: Car ran over Bridge & into Canal

22. *I hereby certify that I attended the deceased from* Inspection only, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* About 24 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche M.D. Coroner 583

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 7-9-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 7, 1969

24c. NAME OF CEMETERY OR CREMATORY: Elysian Burial Gardens

24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: July 10, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Thomas C. Flahiff

LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 3 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 2 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 2 0 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

JUL 1 0 1985

JUL 2 9 1987

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3189
Local Reg. No. 320
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital DOA 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kuna
d. STREET ADDRESS (If rural, give location) 214 Boise Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Marion	Lee	Nikirk	July 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years on birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 5	5-12-1899	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
dairy farmer 04	dairy - farming	Greenwood, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Edgar Nikirk	Illinois	Ora Betty Cline	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	500-07-4254	Irene Nikirk	Kuna, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden death

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic Heart Disease — 5+ years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2-12-69, 19____, *to* 7-2-69, 19____, *that I last saw the deceased alive on* 5-9-69, 19____, *and that death occurred at* ?m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	222 East Elm, Caldwell, Idaho	7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 5,1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Mrs. Martina Walmsley	A. E. Alden	299

FIRM NAME: Alden-Waggoner

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 2 2 1969

JUL 3 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of **Marion Lee Nikirk**

now lying buried in **Emmett, Idaho** Cemetery, in the City or Town of **Emmett**

County of **Gem** State of Idaho, who died on the **1st** day of **July**, **'69**, Aged **70** years ____ months

____ days, the cause of death being **Acute Myocardial Infarction** and not directly or indirectly by diphtheria;(membranous croup);scarlet fever;smallpox;leprosy;asiatic cholera;typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Dr. Hubler attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by **private** private or railway conveyance

to **Kuna** Cemetery in the City or Town of **Kuna** County of **Ada**

State of **Idaho** to take effect upon the approval by the local board of health of the City, Town, or County of **Gem** it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this **28th** day of **August**, A.D. 19**69**.

Permit issued to:
Shepherd Mortuary
415 12th Ave. So.
Nampa, Idaho 83651

W. W. Benson
by _____
Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of _____ State of Idaho, this _____ day of _____, 19___.

_____
Health Officer

FORM BH 56-019

AUG 2 8 1969

TITLE 39, CHAPTER 2, VOL. 7 OF THE IDAHO CODE

"Sec. 39-211. No body shall be disinterred within the State of Idaho except upon a permit granted by the State Board of Health. The forms of disinterment permits shall be prepared by the State Board of Health. Disinterment and removal must be done under the personal supervision of a licensed embalmer, and must be done at an hour when there is the least possible exposure. Only such persons as are actually necessary shall be present. The coffin shall not be opened either at place of disinterment or place of destination, except special permit be issued by the State Board of Health. And in case of disinterment of bodies dead by reason of contagious and infectious diseases, as shown by the certificate of death given by the attending physician, the sexton and all other persons engaged in such removal or being present shall immediately thereafter change their clothing and properly disinfect their hands, head and face, provided, that such disinterment may also be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every permit: provided, also, that in case of any contagious and infectious disease where remains are to be shipped to points in other states, permission must first be obtained from the Secretary of State Board of Health of such State. The State Board of Health may also issue a special disinterment permit for legal purposes. This permit for legal purposes shall be granted only upon application of a prosecuting attorney or the Attorney General of this State, stating therein such facts which make it evident to the State Board of Health that the ends of justice require that disinterment be permitted. Such special disinterment for legal purposes shall be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every such special disinterment permit for legal purposes."

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 11 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3190
Local Reg. No. 313
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell | LENGTH OF STAY (in this place): 0-6-0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakley's Nursing Home 171

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middleton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Amelia | b. (Middle) A. | c. (Last) Chaney

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 12, 1878

9. AGE (In years last birthday): 91 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): C

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Thomas | BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Ernestine Misselt | BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): O | (If yes, give war or dates of service): O

16. SOCIAL SECURITY NO.: 519-42-2311

17. INFORMANT'S OWN SIGNATURE: Martin C. Walmsley | ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

595X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cystitis — 4 days
DUE TO (c) Advanced age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19 55, *to* 7-2, 19 69, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 9:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Charles E Kennick 284 | (Degree or title): MD | **23b. ADDRESS**: 1819 Ellis Ave Caldwell Idaho | **23c. DATE SIGNED**: 7-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial | **24b. DATE**: July 7, 1969 | **24c. NAME OF CEMETERY OR CREMATORY**: Middleton, Cemetery | **24d. LOCATION** (City, town, or county) (State): Middleton, Idaho

DATE REC'D BY LOCAL REG.: July 10, 1969 | **REGISTRAR'S SIGNATURE**: Mrs. Martin Walmsley | **25. EMBALMER**: James R. Dakan | **LICENSE NO.**: E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3191
Local Reg. No. 326
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Route #1, Nampa

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor Nursing Home 30
d. STREET ADDRESS (If rural, give location): Route #1, Nampa

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Idell	A.	Albers	July 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Jan. 26, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 57	home	Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harley Olcott	Illinois	Mattie Beard	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-62-9794	Adrian D Albers	Nampa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis

~~DUE TO (c)~~

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Generalized Arthritis

4369

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July, 1958 *to* 4 July, 1969, *that I last saw the deceased alive on* 4 July, 1969, *and that death occurred at* — m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Marquam MD	Nampa Idaho	8 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 7, 1969	Hillcrest Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 14, 1969	Mrs. Martin Walser	Richard W. Messenbrink	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3192
Local Reg. No. 314
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 14 — JUL 1 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp. 05

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Florida 10
b. COUNTY: Orange
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orlando
d. STREET ADDRESS (If rural, give location): 624 Dorado Avenue

3. NAME OF DECEASED (Type or Print): a. (First) John — b. (Middle) D. — c. (Last) King Jr.

4. DATE OF DEATH: (Month) July (Day) 4 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1

8. DATE OF BIRTH: June 5, 1944

9. AGE (In years last birthday): 25 — IF UNDER 1 YEAR: Months 0, Days 29 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boat Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Corect Boat Co.

11. BIRTHPLACE (State or foreign country): Springfield, Mass.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John King — BIRTHPLACE: Moultrie, Georgia

14. MOTHER'S MAIDEN NAME: Lois H. Frint — BIRTHPLACE: Long Branch, N. J.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): 2 8

16. SOCIAL SECURITY NO.: 267-68-1631

17. INFORMANT'S OWN SIGNATURE: X Lois H. King — ADDRESS

8199

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): rib fractures, lung damage — 11 DAYS

DUE TO (c): auto accident — 11 DAYS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: pneumothorax — 11 DAYS

19a. DATE OF OPERATION: 25 JUN 69, 27 JUN 69

19b. MAJOR FINDINGS OF OPERATION: Lung consolidation; multiple rib fractures. pneumothorax

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 23 JUNE, 1969, *to* 4 July, 1969, *that I last saw the deceased alive on* 3 JULY, 1969, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 36 MD — **23b. ADDRESS**: 222 E. Logan Caldwell — **23c. DATE SIGNED**: 7 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal — **24b. DATE**: July 8, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Woodlawn Cemetery — **24d. LOCATION** (City, town, or county) (State): Orlando, Florida

DATE REC'D BY LOCAL REG.: July 10, 1969 — **REGISTRAR'S SIGNATURE**: Mrs. Martina Walmsley

25. EMBALMER: Leonard C. Flahiff — LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUL 1 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED JUL 17 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3193
Local Reg. No. 328
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 66
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1616 Cleveland

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Thirza	Bee	Smith	July 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Feb. 6, 1886	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
C		Derby, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William H. Culter	Unknown	Katie Bird Sparling	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
O	C	519-46-1188	Gladys M. Smith	

MEDICAL CERTIFICATION

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY EMBOLI — INTERVAL BETWEEN ONSET AND DEATH: 2 d.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD — 20 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Previous Myocardial Infarct 1 yr.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 1, 1969, *to* July 4, 1969, *that I last saw the deceased alive on* 4 July, 1969, *and that death occurred at* 12:5 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald D. Price MD	Caldwell, Ida.	7/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 8, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 16, 1969	Mrs. Martina Walmsley	Kenneth E Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3194
Local Reg. No. 332
Reg. Dist. No. 360

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (If this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkview Manor Nursing Home 376

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Rural Route #4, Nampa

3. NAME OF DECEASED (Type or Print)
a. (First): Lorena
b. (Middle): M.
c. (Last): Ward

4. DATE OF DEATH (Month) (Day) (Year): July 4, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: February 17, 1890
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert E. Mendenhall — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: Ruth Ann Mobley — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-24-6821A
17. INFORMANT'S OWN SIGNATURE: Harry L. Ward — ADDRESS: Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiovas

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) cular disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 8, 1964 *to* July, 1969, *that I last saw the deceased alive on* July 3, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Graydon O. Chow MD 115
23b. ADDRESS: Nampa Ida
23c. DATE SIGNED: 11 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: July 22, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3195
Local Reg. No. 316
Reg. Dist. No. 360

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JUL 11 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF [illegible] (If outside place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 240 High St.

3. NAME OF DECEASED (Type or Print)
a. (First): HELEN
b. (Middle): L.
c. (Last): CARL

4. DATE OF DEATH (Month) (Day) (Year): July 5, 1969

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 15, 1907
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sedalia Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John B. Light — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Emma Pfieffer — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 491-07-5150
17. INFORMANT'S OWN SIGNATURE: x William H. Carl — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2022

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Primary lymphoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): generalized
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1966, *to* July 5, 1969, *that I last saw the deceased alive on* 1 July, 1969, *and that death occurred at* 4:20A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J B Marvaisen 326 wp 1
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: July 7 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Crown Hill Cemetery
24d. LOCATION (City, town, or county): Sedalia (State): Missouri

DATE REC'D BY LOCAL REG.: July 10, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 31 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 14 1985

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 3196
Local Reg. No. 323
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 11 1969 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): WR 30 7
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 623 9th Ave. North o-o-o

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1801 3rd. Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Natalia	Teresa	Dunn	July 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	Oct. 22, 1896	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Maker 01	At Home	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Fillmore	Texas	Permila Anna Warner	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519 01 6929A	[signature]	Ontario, Oregon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD — 3 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Appx. 1968 3:10A, *to* July 7, 19 69, *that I last saw the deceased alive on* July, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 326	MD	Nampa, Idaho	July 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-10-69	Dry Creek Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Mrs. Martina Walmsley	M. B. Shepherd	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3197
Local Reg. No. 324
Reg. Dist. No. 360

Certificate of Death

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
STAY (in this place): 1 1/2 yrs. 102
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D. O. A. -Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Rt. # 3,

3. NAME OF DECEASED (Type or Print)
a. (First): KENTON
b. (Middle): L.
c. (Last): BANNER

4. DATE OF DEATH (Month) (Day) (Year): July 8, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant 02
8. DATE OF BIRTH: Nov. 19, 1967
9. AGE (In years last birthday): 1
IF UNDER 1 YEAR: Months 7 Days 19
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home 0
10b. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Banner
BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Geraldine Patterson
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 0
(If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Samuel Harvey Banner
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) DROWNING

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/19/, 19 67 *to* 7/8/, 19 69, *that I last saw the deceased alive on* 6/5/, 19 69, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert K Bona 053 Mrt /
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 7/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial /
24b. DATE: 7/11/69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Gardens
24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: July 14, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Joe W. Sinifini
LICENSE NO.: E-496

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Alsip [illegible] FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3198
Local Reg. No. 336
Reg. Dist. No. 360

RECEIVED
JUL 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): years 10
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boulevard Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 142
d. STREET ADDRESS (If rural, give location): 472 Nampa-Caldwell Blvd.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	OLLIE	BELL	RICHEY	July 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Single	Oct. 23, 1877	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Teacher 12	School Teacher	Norwich, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William G. Richey	Ohio	Isabell Taylor	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2 0	506-52-2948A	X Ruth H. Jain	Nampa, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia Hypostatic	1 day
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Carcinoma Breast c Bone Metastasis	4 yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerotic Cerebral Vascular Disease c Chronic Brain Syndrome	7 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-29, 1962, *to* 7-11, 1969, *that I last saw the deceased alive on* 7-9, 1969, *and that death occurred at* 7:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C Horton 245 MD		1223-7 St So, Nampa	7-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Trans-Burial	7/17/69	Forest Lawn Cemetery	Omaha, Nebraska

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 23, 1969	Mrs. Martina Walmsley	Roy A Sinclair	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 29 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 26 1987

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3199
Local Reg. No. 337
Reg. Dist. No. 360

RECEIVED JUL 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-60
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 2814 So. Indiana

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lillie	Ruth	Torkelson	July 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	February 24, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 0
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): McDonald Co., Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Hart — BIRTHPLACE: Michigan
14. MOTHER'S MAIDEN NAME: Lillie Hoffard — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 0
(If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 512-44-4004D
17. INFORMANT'S OWN SIGNATURE: x Mrs. Clara Hay — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 485X Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes Mellitus

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1965, *to* July 11, 1969, *that I last saw the deceased alive on* July 11, 1969, *and that death occurred at* 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 258 Robert H. Jensen, M.D.
23b. ADDRESS: 222 EAST LOGAN
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: July 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Holly Cemetery
24d. LOCATION (City, town, or county) (State): CALDWELL, IDAHO — Holly, Michigan

DATE REC'D BY LOCAL REG.: July 23, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-508
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3200
Local Reg. No. 331
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 18 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 970
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing
d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) J. c. (Last) Percifield

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Jan. 22, 1893

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 0

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Nevada, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Henry Percifield

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Emaline Wolff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): 2 8

16. SOCIAL SECURITY NO.: 519-42-5873 A

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Wayne Percifield

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4d

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Cerebral Arteriosclerosis — 4yrs

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 8 '69 *to* July 12 '69, *that I last saw the deceased alive on* July 12, 1969, *and that death occurred at* 1:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD

23b. ADDRESS: Caldwell Ida

23c. DATE SIGNED: 7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 16, 1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: July 17, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Rodney C. Dakan

LICENSE NO.: E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3201
Local Reg. No. 329
Reg. Dist. No. 360

RECEIVED JUL 18 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lake Lowell- Nampa, Rural

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa- Rural
d. STREET ADDRESS (If rural, give location): R# 4

3. NAME OF DECEASED (Type or Print): a. (First) GARY b. (Middle) LEE c. (Last) SCHOLL

4. DATE OF DEATH: (Month) July (Day) 12, (Year) 1969

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married /

8. DATE OF BIRTH: Sept. 17, 1951

9. AGE (In years last birthday): 17 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sturgis South Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dave Scholl BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Elda Ulrich BIRTHPLACE: South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 519 62 6831

17. INFORMANT'S OWN SIGNATURE: Family Records, By: Jany J. Rivers ADDRESS: Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9180

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning, Accidental — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Lake Lowell

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Canyon. 140 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-12-69 6:45 p. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Drowned While Helping a brother Swimmer.

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:45 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wenk 585 Inc. Coroner

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 17, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: July 17, 1969

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: Roger Sinsel LICENSE NO. E-498

FIRM NAME: Alsip Funeral Chapel Alsip Funeral Chapel Nampa, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 7 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3202
Local Reg. No. 333
Reg. Dist. No. 360

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 23 1969
Bureau of Vital Stat

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 511-14 Ave. So.

3. NAME OF DECEASED (Type or Print)
a. (First): Frances
b. (Middle): A.
c. (Last): Lantz

4. DATE OF DEATH (Month) July (Day) 13, (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 24, 1902
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Jewell County Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alfred C. Faris — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Martha Tippin — BIRTHPLACE: IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-01-4570 B
17. INFORMANT'S OWN SIGNATURE: Wilbur G. Lantz — ADDRESS: Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

402X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Edema 8 — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive Heart disease — 15 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Vasculitis, Generalize rheumatoid arthritis — 10 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18-62, 19__, *to* 7-13-69, 19__, *that I last saw the deceased alive on* 7-13-69, 19__, *and that death occurred at* 2:10A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold W. Brown MD
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 7-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: July 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county): Nampa (State): Idaho

DATE REC'D BY LOCAL REG.: July 22, 1969
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: Marvin R. Hickhila
LICENSE NO.: E-515

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Ahlp Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 1 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3203
Local Reg. No. 334
Reg. Dist. No. 360

RECEIVED JUL 23 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home- Eagle Heights

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): R# 2 Eagle Heights

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Melvin	E.	Brandt		July	14	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	March 22, 1946	23				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ed Brandt — BIRTHPLACE: Nampa Idaho
14. MOTHER'S MAIDEN NAME: Amy Longwill — BIRTHPLACE: Diamond, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 618-54-1638
17. INFORMANT'S OWN SIGNATURE: Edwin J. Brandt — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Astrocytoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr -

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1929

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-17, 1969, *to* July 14, 1969, *that I last saw the deceased alive on* 7-3, 1969, *and that death occurred at* 1:55 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] MD
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: July 22, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Roy A. Sinigiani — LICENSE NO.: E-496
FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 4 1969

AUG 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3204
Local Reg. No. 335
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 19 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hos.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon (40)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Caldwell
d. STREET ADDRESS (If rural, give location): Rt # 3

3. NAME OF DECEASED (Type or Print): a. (First) Frank; b. (Middle); c. (Last) Hainy

4. DATE OF DEATH: (Month) July (Day) 14, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Sept. 12, 1899

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Dakota
Wessington Springs, So.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Hainy
BIRTHPLACE: Czechoslovakia

14. MOTHER'S MAIDEN NAME: Mary Phoba
BIRTHPLACE: Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-42-2619

17. INFORMANT'S OWN SIGNATURE: X Ransom E. Hainy
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HYPOSTATIC PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 24 HR.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CARCINOMATOSIS ABDOMEN — 3 mo.
DUE TO (c) CA STOMACH — 6 mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10 JULY 69
19b. MAJOR FINDINGS OF OPERATION: MASSIVE INTRAPERITONEAL CA INCL. LIVER
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9 JUL, 1969, *to* 14 JUL, 1969, *that I last saw the deceased alive on* 14 JUL, 1969, *and that death occurred at* 2:25 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: 222 E. Logan Caldwell
23c. DATE SIGNED: 17 JUL 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: July 22, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walsh

25. EMBALMER: Leonard C. Flaniff
LICENSE NO.: E-481
FIRM NAME: Flaniff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3205
Local Reg. No. 354
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place) 1 week 307
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 210 Cleveland Blvd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Louis		Dretke	July	15,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Oct. 11, 1881	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Woodsman 17	Forestry	Massillon, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Dretke	Germany	Unknown	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	710-16-4392	X Louis Dretke	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2041

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gastrointestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 12 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Lymphocytic Leukemia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1965 *to* 7/15, 1969, *that I last saw the deceased alive on* 7/15, 1969, *and that death occurred at* 10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald C. Bauman 031 M.D.	1819 Ellis Caldwell	7/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 19, 1969	Terrace Lawn Memorial Gardens	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 30, 1969		G.W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3206
Local Reg. No. 344
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 28 1969

1. PLACE OF DEATH
a. COUNTY: CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 15YRS 11 MOS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 STINSON

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 35 STINSON

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROY	E	HOLLIDAY	JULY 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED 3	FEB. 2, 1901	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
OWNER CONFECTIONARY 32	Candy Making	COLUMBIA, IOWA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
ELLIS HOLLIDAY	OHIO	NANCY MURR	IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		482 01 0256	Roneta E Holliday	Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Inspection only., 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 9:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry E Wesch M.D. Coroner 583	Nampa, Idaho	7-22-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	JULY 18, 1969	HILL CREST MEMORIAL GARDENS	NAMPA, CANYON, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 25, 1969	Mrs. Martina Wolmsley	Shepherd	423

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3207
Local Reg. No. 338
Reg. Dist. No. 360

Certificate of Death

RECEIVED
JUL 25 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 1 month 20
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 132 Davis Ave.,

3. NAME OF DECEASED (Type or Print)
a. (First): JOHANNA
b. (Middle): RINDSBERGER
c. (Last): CAPELL

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 2, 1873
9. AGE (In years last birthday): 95 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Bavaria, Germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: No Record — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-54-0464J1
17. INFORMANT'S ~~OWN~~ SIGNATURE: Preston Capell — ADDRESS: Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Organic Brain Syndrome
DUE TO (c): Old age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/3/, 19 43, *to* 7/17/, 19 69, *that I last saw the deceased alive on* 7/17/, 19 69, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 454 Jos Saltzer M.D.
23b. ADDRESS: Nampa Ida
23c. DATE SIGNED: 7/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/18/69
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: July 24, 1969
REGISTRAR'S SIGNATURE: Mrs Martin Walmsley
25. EMBALMER: Tony J. Krouch
LICENSE NO.: E-447

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 28 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3208
Local Reg. No. 346
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nampa City Jail 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Ft. Hall (Idaho) b. COUNTY Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ft. Hall Indian Reservation
d. STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	THERON	JOSEPH	TAQUENA	July 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Indian	Single	May 10, 1939	30		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	No Record	Fort Hall Reservation, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Taquena	Idaho	Sylvia Tavingo	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	No Record	X Dorothea C. Taquenaual	Nampa, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ethyl & Methyl Alcohol Intoxication — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Pulmonary Infarct
Contusions head & Face

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
	City Jail 21	Nampa	Canyon 141	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
7-17-69 about 2p m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Not Determined

22. *I hereby certify that I attended the deceased from* Inspection only, 19____ *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 2.00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche 583	M. D. Coroner 4	Nampa, Idaho	7-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Trans-Burial 3	7/21/69	Pocatello, Idaho	Pocatello,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 25, 1969	Mrs. Martina Walmsley	Marvin R. Hillside	515

FIRM NAME: AISD FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3209
Local Reg. No. 343
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 28 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 050 Bureau
c. LENGTH OF STAY (in this place): 1 Day 30/
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Kuna
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Leon
b. (Middle): B.
c. (Last): Trew

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 13, 1877
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer/ 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Gibbin, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilmont P. Trew — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Ella George — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 2 no — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 540 26 7030
17. INFORMANT'S OWN SIGNATURE: X Lyle Trew — ADDRESS: Nampa, Idaho

4319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c): Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Old age

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/14/, 19 69, *to* 7/17/, 19 69 *that I last saw the deceased alive on* 7/17/, 19 69 *and that death occurred at* 8:05 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: A54 Jos Seltz (Degree or title) 1
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 7/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7-18-69
24c. NAME OF CEMETERY OR CREMATORY: Ansley Cemetery
24d. LOCATION (City, town, or county) (State): Ansley, Nebraska

DATE REC'D BY LOCAL REG.: July 25, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473
FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 2 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3210
Local Reg. No. 342
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JUL 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 75 Min 5/5
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Canyon 42
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 120 12th Ave. South

3. NAME OF DECEASED (Type or Print): a. (First) Herbert b. (Middle) D. c. (Last) Biggs

4. DATE OF DEATH: (Month) July (Day) 18, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 27

8. DATE OF BIRTH: July 31, 1906

9. AGE (In years last birthday): 62 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): North Dakota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: No Record — BIRTHPLACE: No Record

14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 548 12 8021

17. INFORMANT'S OWN SIGNATURE: Mrs Donna McGregor — ADDRESS: Mt. Home, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): A.S.H.D.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/18/, 1969, *to* 7/18/, 1969 *that I last saw the deceased alive on* 7/18/, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Richard C. Draper M.D. 656 (Degree or title)

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-23-69

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: July 25, 1969

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: [signature] Shepherd Mortuary

LICENSE NO.: 413

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3211
Local Reg. No. 365
Reg. Dist. No. 360

RECEIVED
AUG 8 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 32 days 332
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1919½ Maple Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Sarah
b. (Middle): E.
c. (Last): Boyer

4. DATE OF DEATH (Month) (Day) (Year): July 18, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 14, 1887
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Emily City, Michigan
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Levi C. Clark — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Wilda Currin — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 543-28-9494
17. INFORMANT'S OWN SIGNATURE: H. B. Boyer — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2041

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Symphacytic Scuhemia — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-17-69, 19__, *to* 7-18-69, 19__, *that I last saw the deceased alive on* 7-18-69, 19__, *and that death occurred at* 6:30A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Charles E. Reed M.D. 374 1
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: July 23, 1969
24c. NAME OF CEMETERY OR CREMATORY: St. Joesph Memorial Park
24d. LOCATION (City, town, or county) (State): St. Joesph, Mo.

DATE REC'D BY LOCAL REG.: August 7, 1969
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED JUL 28 1969

Certificate of Death

STATE OF IDAHO

State File No. 3212
Local Reg. No. 340
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa,
d. STREET ADDRESS (If rural, give location): 443 Nampa Caldwell Blvd.

3. NAME OF DECEASED (Type or Print): a. (First) Lyle b. (Middle) Duane c. (Last) Buhler

4. DATE OF DEATH (Month) (Day) (Year): July 18, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: May 20, 1953

9. AGE (In years last birthday): 16 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: Nampa High School

11. BIRTHPLACE (State or foreign country): Council, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Duane E. Buhler — BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Loveta Shumway — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 66 3213

17. INFORMANT'S OWN SIGNATURE: X Duane E. Buhler — ADDRESS: Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken Neck. — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto - Pedestrian Accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractures Left Leg & Right Femur

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway
21c. (CITY, TOWN, OR TOWNSHIP) So. Side Blvd (COUNTY) Canyon 140 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 - 18 - 1969 7 A.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Walking in Road when a Car hit him

22. *I hereby certify that I attended the deceased from* Inspection, 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John C Weschler M.D. Coroner
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-21-69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: July 25, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmer
25. EMBALMER: E. E. Shepherd
LICENSE NO.: 473
FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3213
Local Reg. No. 349
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 124 Juniper St.

3. NAME OF DECEASED (Type or Print)
a. (First): JENNIE
b. (Middle): A.
c. (Last): LINDBLOOM

4. DATE OF DEATH (Month) (Day) (Year): July 18, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 3, 1884
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (State or foreign country): Fjarakulla, Kokon, Sweden
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Sven Munson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Hannah (No Record) — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-60-1923T
17. INFORMANT'S OWN SIGNATURE: X Richard A Lindbloom — ADDRESS: Boise Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

481X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): R + Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic Cardio-Vascular Disease — 5 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 1969, *to* July, 1969, *that I last saw the deceased alive on* July 18, 1969, *and that death occurred at* 7:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Graydon O Cron MD 115
23b. ADDRESS: Nampa Ida
23c. DATE SIGNED: 24 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: July 28, 1969
REGISTRAR'S SIGNATURE: Irene N Kantz RN
25. EMBALMER: Marvin R. Hickfield — LICENSE NO. 515

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3214
Local Reg. No. 353
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 4 Months 20 d
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blvd. Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Nampa
d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Vernie	Earl	Booth	July	19,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	Married 3	June 20, 1895	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04	Farming	Leola, Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elmer E. Booth	Wisconsin	Aurie Stowell	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes / W.W.I 3 4339	529 20 1105	Mrs. V.E. Booth	Nampa, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cerebral Thrombosis — 4 mo,

DUE TO (c) Arteriosclerotic cerebral Vascular Disease — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-5, 1953, *to* 7-19, 1969, *that I last saw the deceased alive on* 7-16, 1969, *and that death occurred at* 8:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J.C. Horton MD	Nampa, Idaho	7-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 22, 1969	Star Cemetery	Star, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 30, 1969		H.B. Shepherd	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 19 1999

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 29 10

State File No. 3215
Local Reg. No. 352
Reg. Dist. No. 360

BIRTH NO.

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): one
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 3412 Iowa

3. NAME OF DECEASED (Type or Print): a. (First) Marvin; b. (Middle) LeRoy; c. (Last) Haney

4. DATE OF DEATH (Month) (Day) (Year): July 19, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 25, 1917

9. AGE (In years last birthday): 51
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): C

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Glenwood, Iowa

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: William H. Haney
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Nina H. Trobaugh
BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): O
(If yes, give war or dates of service): O

16. SOCIAL SECURITY NO.: 519-01-9589

17. INFORMANT'S OWN SIGNATURE: x Mildred N. Haney
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1, 1969, *to* July 19, 1969, *that I last saw the deceased alive on* July 19, 1969, *and that death occurred at* 11 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD

23b. ADDRESS: Caldwell Ida

23c. DATE SIGNED: 7-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 23, 1969

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: July 28, 1969

REGISTRAR'S SIGNATURE: Irene N. Tanta RN

25. EMBALMER: Kenneth E. Spence

LICENSE NO.: E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 28 1969 Bureau of Vital Statistics

State File No. 3216
Local Reg. No. 341
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 1 Year 10/
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 224 Lake Lowell Ave ood

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 224 Lake Lowell Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Frank b. (Middle) Russell c. (Last) Hughey

4. DATE OF DEATH: (Month) July (Day) 19 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Nov. 27 1911

9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor 11

10b. KIND OF BUSINESS OR INDUSTRY: Concrete

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Hughey — BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Pearl Hilderbrand — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 512-16-4169

17. INFORMANT'S OWN SIGNATURE: X Bertha E. Hughey — ADDRESS: Nampa, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Occlusion. 4109

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection Only, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 4:A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wenck M.D. Coroner 583 11

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 7-22-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-23-69

24c. NAME OF CEMETERY OR CREMATORY: Rosedale Memoral Gardens

24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: July 25, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Donald F Brown

LICENSE NO.: E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 2 0 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3217
Local Reg. No. 370
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 13 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 0-0-0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor Nursing Home 307

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 006 Cleveland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nathaniel	Crew	Marmon	July 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Dec. 13, 1873	95				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
0		Zanesfield, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Marmon	Ohio	Melissa Walker	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	0	519-60-9058	Loren E. Marmon	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug [illegible], 1967, *to* July 19, 1969, *that I last saw the deceased alive on* June [illegible], 1969 *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Nampa, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 21, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 12, 1969	Mrs. Martina Walmsley	Kenneth E. Spencer	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3218
Local Reg. No. 345
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Nampa-Caldwell
c. LENGTH OF STAY (in this place): Hrs. 400
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Near Lake Lowell Dam 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa,
d. STREET ADDRESS (If rural, give location): 216 Delaware St.,

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DANNY	RAY	WANGELIN	July 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	Jan. 17, 1955	14				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	at Home	Payette, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marvin Wangelin	Wisconsin	Wanda Tevebaugh	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Marvin E. Wangelin	Nampa, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9109 Drowning, Accidental — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE? (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Lake Lowell	Canyon 140 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
July 19 1969 4:30 PM		Went down for no apparent reason

22. *I hereby certify that I attended the deceased from* Inspection only, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 4:30 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche M.D. 583 Coroner	Nampa, Idaho	7-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 23, 1969	Hillcrest Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 25, 1969	Mrs. Martina Walmsley	Marvin R. Liddle	515

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3219
Local Reg. No. 339
Reg. Dist. No. 360

Certificate of Death

RECEIVED
JUL 25 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho
c. LENGTH OF STAY (in this place): 7hrs 407
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Camas 130
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield, Idaho
d. STREET ADDRESS (If rural, give location): Fairfield, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): FREEMAN
b. (Middle): J
c. (Last): LOVE

4. DATE OF DEATH (Month) (Day) (Year): 7 20 69

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 4, 1883
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months 10, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Rogers, Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Love — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0 No
16. SOCIAL SECURITY NO.: 519-36-2710A
17. INFORMANT'S OWN SIGNATURE: Esther G. Collins — ADDRESS:

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: a few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchiectasis — indefinite
DUE TO (c) Emphysema — indefinite

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Stress gastric ulceration — 1-2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-19, 1969, *to* 7-20, 1969, *that I last saw the deceased alive on* 7-20-69, 19___, *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Charles Elamick 280 MD 1
23b. ADDRESS: 1819 Elles St Caldwell Idaho
23c. DATE SIGNED: 7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7/24/69
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: July 24, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff — LICENSE NO. E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (IDCA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
JUL 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3220
Local Reg. No. 348
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Rt. # 2
c. LENGTH OF STAY (in this place): 0-0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Abner	Harris	July 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	April 12, 1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
0		Eufaula, Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Grant Harris	Ala.	Lizzie Boogh	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	0	527-20-4435	Ruby Harris	

MEDICAL CERTIFICATION

4189

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Inspection only, 19___, *to* ____, 19___, *that I last saw the deceased alive on* ____, 19___, *and that death occurred at* 7 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jerry C. Wesele 583 M. D. Coroner	Nampa., Idaho	7-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 24, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 28, 1969	Irene M. Kendall	Rodney W. Dekon	E-505

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: AUG 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 29 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3221
Local Reg. No. 350
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
c. LENGTH OF STAY (in this place): 3 yrs. 103
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 4

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
d. STREET ADDRESS (If rural, give location): Route # 4

3. NAME OF DECEASED (Type or Print)
a. (First): Lloyd
b. (Middle): Marvin
c. (Last): Shields

4. DATE OF DEATH (Month) (Day) (Year): July 21, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 22, 1903
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months 1, Days 29 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Council Bluffs, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Calvin Shields — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Myrtle Sheaffer — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 8
16. SOCIAL SECURITY NO.: 542-24-3684
17. INFORMANT'S OWN SIGNATURE: Hedwig J. Shields — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection Only *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 8:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wesche M.D. Coroner 4 — 583
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 7-24-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-24-1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: July 28, 1969
REGISTRAR'S SIGNATURE: Irene N. Kanta R.N.
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Charel

DUTIES:

MAR 27 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 20 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 10 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUN 17 1982

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3222
Local Reg. No. 363
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 6 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 12 YRS. 11 2
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 212 19th AVE. SO. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 212 19th Ave. South

3. NAME OF DECEASED (Type or Print)
a. (First): F.
b. (Middle): Enid
c. (Last): Van Sickle

4. DATE OF DEATH (Month) (Day) (Year): July 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 14, 1901

9. AGE (In years last birthday): 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Fish Culturestz

10b. KIND OF BUSINESS OR INDUSTRY: Trout Farm

11. BIRTHPLACE (State or foreign country): Marysville, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank O. Van Sickle
BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Alice Harmon
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 20

16. SOCIAL SECURITY NO.: 4109

17. INFORMANT'S OWN SIGNATURE: X Fenny Van Sickle
ADDRESS: Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes Mellitus

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec 7, 19 53, *to* July 21, 19 69, *that I last saw the deceased alive on* June 17, 19 69, *and that death occurred at* 7:45 PM *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C Wesche - 560
(Degree or title): M. D.
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 7-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-25-69
24c. NAME OF CEMETERY OR CREMATORY: Joplin Cemetery
24d. LOCATION (City, town, or county) (State): Ada County, Idaho

DATE REC'D BY LOCAL REG.: August 5, 1969
REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473
FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 29 1969

Certificate of Death

STATE OF IDAHO

State File No. 3223
Local Reg. No. 351
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (RCA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Canyon 141 Bure

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

c. LENGTH OF STAY (in this place): 00?

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakley's Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Canyon 141

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

d. STREET ADDRESS (If rural, give location): 1015 Cleveland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Diena		Alexanderson	July 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Dec. 7, 1876	92				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
0		Kanyen, The Neitherlands	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Garrett Koops	The Neitherlands	Katrina Tiinman	The Neitherlands

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
0	0	518-54-0830JI	X Kenneth Alexanderson	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis, Generalized — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/65, 19__, *to* 7/22, 19 69, *that I last saw the deceased alive on* 7/22, 1969, *and that death occurred at* 11 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X Kenneth Dawson M.D. 034	Caldwell Idaho	7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 25, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 28, 1969	Irene N. Kenta R.N.	Kenneth E. Spence E-395	

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3224
Local Reg. No. 360
Reg. Dist. No. 360

BIRTH NO. 69-6969

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 0720
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1008-6th. Street North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JULIE	ANN	FLOWERS	July	24	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Infant	July 23, 1969		1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
--------	-----	Nampa, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Norman Flowers	Idaho	Mary Thomason	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
------		--------	Norman W. Flowers	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 7701 Cerebral anoxia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) placental insufficiency
DUE TO (c) Abruptio placenta

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 23, 1969 *to* 24 July, 1969 *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
326 [illegible] /	Nampa, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/29/69	Mt. Calvary Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 31, 1969	Mrs Martina Walmsley	Joyce Livingston	E-496

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3225
Local Reg. No. 361
Reg. Dist. No. 360

RECEIVED
AUG - 4 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Box 286 Wilder
d. STREET ADDRESS (If rural, give location): Box 286

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): Ama
c. (Last): Hawkins

4. DATE OF DEATH (Month) (Day) (Year): July 24, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 14, 1901
9. AGE (In years last birthday): 67
IF UNDER 1 YEAR: Months 7 Days 10
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Fairland, Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Rex
BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Eliza Smith
BIRTHPLACE: Fairland, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 445-12-7861
17. INFORMANT'S OWN SIGNATURE: X Gullian B. Hampton
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Diabetes - duodenal ulcer

INTERVAL BETWEEN ONSET AND DEATH: 4 Days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-20, 1969, to 7-24, 1969, that I last saw the deceased alive on 7-24, 1969, and that death occurred at 6 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title): [signature]
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-28-1969
24c. NAME OF CEMETERY OR CREMATORY: Wilder Cemetery
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: Aug. 1, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 19 2016

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3226
Local Reg. No. 358
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 220 E. Logan 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 4

3. NAME OF DECEASED (Type or Print): a. (First) Joseph b. (Middle) E. c. (Last) Apland

4. DATE OF DEATH (Month) (Day) (Year): July 25, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 31, 1891

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.: 77

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Slater, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: K. O. Apland — BIRTHPLACE: Slater, Iowa

14. MOTHER'S MAIDEN NAME: Torrena Erickson — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): War I 4-1-89

16. SOCIAL SECURITY NO.: 519-40-1046

17. INFORMANT'S OWN SIGNATURE ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 25, 1969, *to* Only, 19___, *that I* did not see *the deceased alive on* July 25, 1969, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 29, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Garden
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: July 31, 1969
REGISTRAR'S SIGNATURE: Mrs Martin Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-508
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. BUREAU OF VITAL STATISTICS, BOISE, IDAHO
Address correspondence to [illegible] (ICA 38-206 and 215.)

DUTIES:

AUG 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 2 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The ~~international~~ classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3227
Local Reg. No. 359
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa c. LENGTH OF STAY (In this place) Years 100	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital-Nampa 050	d. STREET ADDRESS (If rural, give location) 107 Juniper Street

3. NAME OF DECEASED (Type or Print)	a. (First) ONA	b. (Middle)	c. (Last) STANDLEY	4. DATE OF DEATH (Month) (Day) (Year) July 26, 1969		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Nov. 3, 1896	9. AGE (In years last birthday) 72	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Clarkston, Utah	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James E. Stewart	BIRTHPLACE Utah		14. MOTHER'S MAIDEN NAME Emily Jane Bassett	BIRTHPLACE Utah		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2	(If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 519-07-6997D	17. INFORMANT'S OWN SIGNATURE × Donna Provoit	ADDRESS 107 Juniper		

18. CAUSE OF DEATH 4330
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Thrombosis	Inks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral arteriosclerosis	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	HCVD	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 12-1-66, 19__, *to* July 26, 19 69, *that I last saw the deceased alive on* July 25, 19 69, *and that death occurred at* 6:20 am *from the causes and on the date stated above.*

23a. SIGNATURE Marvin Lloyd (Degree or title) 730	23b. ADDRESS Nampa Ida	23c. DATE SIGNED 7-28-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7/29/69	24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery	24d. LOCATION (City, town, or county) (State) Nampa, Canyon, Idaho
DATE REC'D BY LOCAL REG. July 31, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Don Chinigiani	LICENSE NO. F-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3228
Local Reg. No. 362
Reg. Dist. No. 360

RECEIVED
AUG - 4 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 8 years 108
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park View Manor 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 351 S 20th

3. NAME OF DECEASED (Type or Print): a. (First) AMOS b. (Middle) CHARLIE c. (Last) COX

4. DATE OF DEATH: (Month) July (Day) 27, (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 5
8. DATE OF BIRTH: December 9, 1896
9. AGE (In years last birthday): 72 IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter & Paperhanger
10b. KIND OF BUSINESS OR INDUSTRY: Interior Decorating
11. BIRTHPLACE (State or foreign country): Willow Hill, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wilbur J. Cox BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Minnie Etta Story BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): — —
16. SOCIAL SECURITY NO.: 508-05-4246
17. INFORMANT'S OWN SIGNATURE: Velma Schmidt ADDRESS: Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Right Hemiplegia from a previous Stroke

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-22-, 1960, *to* 7-27-, 1969, *that I last saw the deceased alive on* 7-16-, 1969, *and that death occurred at* 3:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C Wenche 560 (Degree or title): M.D.
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 7-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 29, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rosedale
24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: Aug. 1, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 6 1981

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3229
Local Reg. No. 1
Reg. Dist. No. 520-521

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Orsemus
b. (Middle): Bowman
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: August 18, 1904
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming-retired
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Chesterfield, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Archie Bowman 04 — BIRTHPLACE: Salt Lake City, Ut.
14. MOTHER'S MAIDEN NAME: Nellie Waddell — BIRTHPLACE: Heber, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-42-9469
17. INFORMANT'S OWN SIGNATURE: Una B. Call — ADDRESS: Blackfoot, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 July, 1969, *to* _____, 19__, *that I last saw the deceased* dead *alive on* 12 July, 1969, *and that death occurred at* 3:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: C C Herrera 226 — (Degree or title): MD
23b. ADDRESS: Grace, Idaho
23c. DATE SIGNED: 14 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/16/69
24c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery
24d. LOCATION (City, town, or county) (State): Chesterfield, Caribou, Idaho

DATE REC'D BY LOCAL REG.: 7-14-69
REGISTRAR'S SIGNATURE: Norene Bunn
25. EMBALMER: Theodore S Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3230
Local Reg. No. 2
Reg. Dist. No. 520-521

BIRTH NO.

RECEIVED JUL 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Caribou County 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hiway Near Bancroft
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SODA SPRINGS HOSPITAL 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) LEO c. (Last) SIMS

4. DATE OF DEATH: (Month) July (Day) 15, (Year) 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3

8. DATE OF BIRTH: Oct. 28, 1927

9. AGE (In years last birthday): 41
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Welder and Fitter 21

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Evansville, Indiana

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Ned L. Sims
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Waneta Lynn
BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WWII 2

16. SOCIAL SECURITY NO.: 520 22 9358

17. INFORMANT'S OWN SIGNATURE: Mary Sims
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Skull fracture
INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Hiway
21c. (CITY, TOWN OR TOWNSHIP): Near Bancroft (COUNTY): Caribou (STATE): Idaho

21d. TIME OF INJURY: (Month) July (Day) 15, (Year) 1969 (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR: Truck overturned on wet slippery pavement

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on July 15, 19 69, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Theodore L. Allen 583 Coroner
23b. ADDRESS: Soda Springs, Idaho
23c. DATE SIGNED: 7/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county): Boise, Ida ho (State)

DATE REC'D BY LOCAL REG.: 7-29-69
REGISTRAR'S SIGNATURE: Norene Bunn
25. EMBALMER: Theodore L. Allen Ted Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 30 1969

AUG 1 1969

NOV 30 1995

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3231
Local Reg. No. 3
Reg. Dist. No. 520-521

BIRTH NO.

RECEIVED JUL 30 1969

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou Memorial Hospital 067

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Conda
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) b. (Middle) c. (Last): Carl Joseph Koeneman

4. DATE OF DEATH (Month) (Day) (Year): July 18, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 26, 1893

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal clerk-retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (State or foreign country): Missoula, Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Herman Koeneman
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Sophia Gugal
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W I 3

16. SOCIAL SECURITY NO.: 08 185X

17. INFORMANT'S OWN SIGNATURE: X Dora F. Phelps
ADDRESS: Conda, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer of Prostate with metastases
INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug, 1968, *to* July 18, 1969, *that I last saw the deceased alive on* July 17, 1969, *and that death occurred at* 2:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James Lynch MD
23b. ADDRESS: Soda Springs Idaho
23c. DATE SIGNED: 7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/21/69
24c. NAME OF CEMETERY OR CREMATORY: Butte Cemetery
24d. LOCATION (City, town, or county) (State): Butte, Montana

DATE REC'D BY LOCAL REG.: 7-29-69
REGISTRAR'S SIGNATURE: Norene Gunn
25. EMBALMER: Theodore Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3232
Local Reg. No. 1995
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 28 1969 Bureau

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 57 Years 157
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 934 Miller Avenue 0-0-0

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 934 Miller Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Amelia
b. (Middle):
c. (Last): Fairchild

4. DATE OF DEATH (Month) (Day) (Year): June 27, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 10, 1880
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months 8, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lehi, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Malcohm — BIRTHPLACE: Leed, Yorkshire, Sunderland, England
14. MOTHER'S MAIDEN NAME: Bella Leah Wood — BIRTHPLACE: Leeds Yorkshire, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0 - - - -
16. SOCIAL SECURITY NO.: 519-22-3591T
17. INFORMANT'S OWN SIGNATURE: Owen E. Fairchild — ADDRESS: Burley, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1951, *to* June 27, 1969, *that I last saw the deceased alive on* June 27, 1969, *and that death occurred at* 9:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 283 Mn 1
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 27 June 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: July 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery, Burley, Idaho
24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: July 25, 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Vern B. McCulloch
LICENSE NO.: E-260

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED
JUL 22 1969
Bureau of Vital Statistics

State File No. 3233
Local Reg. No. 1992
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): Lifetime
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 575 South 500 East

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 575 South 500 East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Cal	Ray	Bronson	July 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Dec. 20, 1965	3	6	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child at home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME — BIRTHPLACE: Ray LaMar Bronson, Elba, Idaho
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Maurine Gale Osterhout, Burley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Ray L Bronson Rt #3 Burley, Ida. 83318

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8908

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Burned in accidential dwelling fire — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rural Cassia 161 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 2 69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 4:00 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L O Young 585	Coroner 4	Burley, Idaho	7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 5, 1969	Sunny Cedar Rest Cemetery,	Almo, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 17 1969	Ruth A. Pearson	Ormand Buck	E471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUL 22 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3234
Local Reg. No. 1993
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley rural
c. LENGTH OF STAY (in this place): Lifetime 100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 575 South 500 East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley - rural
d. STREET ADDRESS (If rural, give location): 575 South 500 East

3. NAME OF DECEASED (Type or Print)
a. (First): Lorri
b. (Middle): Rae
c. (Last): Bronson

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married /
8. DATE OF BIRTH: June 21,1967
9. AGE (In years last birthday): 2 — IF UNDER 1 YEAR: Months — Days 11 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child at Home 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rupert, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ray LaMar Bronson — BIRTHPLACE: Elba, Idaho
14. MOTHER'S MAIDEN NAME: Maurine Gale Osterhout — BIRTHPLACE: Burley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0 - - - -
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Ray L Bronson — ADDRESS: Rt 3 Burley, Ida. 83318

890X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Burned in accidental dwelling fire — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rural — Cassia 160 — Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 2 69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 4:00 *P.m., from the causes and on the date stated above.*

23a. SIGNATURE: Le B Young 583 — (Degree or title): Coroner 4
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: July 5,1969
24c. NAME OF CEMETERY OR CREMATORY: Sunny Cedar Rest Cemetery, Almo,
24d. LOCATION (City, town, or county) (State): Idaho

DATE REC'D BY LOCAL REG.: July 17-1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Armand F Burch
LICENSE NO.: E471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3235
Local Reg. No. 1991
Reg. Dist. No. 470

Certificate of Death

RECEIVED
JUL 11 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 10 days 110
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 670

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. STREET ADDRESS (If rural, give location): 400 West - 380 South

3. NAME OF DECEASED (Type or Print)
a. (First): Elma
b. (Middle): Elizabeth
c. (Last): FISHER

4. DATE OF DEATH (Month) (Day) (Year): July 3, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 3, 1917
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Rupert, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ira Hayes Kelly — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Fannie Fern Flake — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0 - - -
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Newel M. Fisher — ADDRESS: Heyburn, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~alcoholic cirrhosis~~ Liver failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) alcoholic cirrhosis — months
DUE TO (c) Chronic alcohol ingestion — yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Duodenal ulcer

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1969, *to* 7-3-, 1969, *that I last saw the deceased alive on* 7-3, 1969, *and that death occurred at* 8:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Samuel J. Hammond 647 Wm. — **23b. ADDRESS**: Box 47 Paul, Idaho — **23c. DATE SIGNED**: 7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Heyburn, Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Charles H Persons — LICENSE NO.: E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 14 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 13 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 2 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3236
Local Reg. No. 1996
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): ---
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print): a. (First) David b. (Middle) Michael c. (Last) McCall

4. DATE OF DEATH (Month) (Day) (Year): July 14, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: July 14, 1969

9. AGE (In years last birthday) If UNDER 1 YEAR: Months / Days. If UNDER 24 HRS.: Hours / Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Burley, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael McCall BIRTHPLACE: Rupert, Idaho

14. MOTHER'S MAIDEN NAME: Susan Cochnour BIRTHPLACE: Burley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Rupert, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7777 Prematurity incompatible with life 1 day.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Premature Delivery.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 14 July, 1969, *to* 14 July, 1969, *that I last saw the deceased alive on* 14 July, 1969, *and that death occurred at* 10:37 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD

23b. ADDRESS: Burley Idaho

23c. DATE SIGNED: 16 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 7/17/69

24c. NAME OF CEMETERY OR CREMATORY: Paul Cemetery

24d. LOCATION (City, town, or county) (State): Paul, Idaho

DATE REC'D BY LOCAL REG.: July 25, 1969

REGISTRAR'S SIGNATURE: Ruth H. Pearson

25. EMBALMER: Jerry K. Lawson LICENSE NO. E-522

FIRM NAME: Paine Mortuary-Burley

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 29 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3237
Local Reg. No. 1998
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 6 days 306
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): R.F.D. # 4

3. NAME OF DECEASED (Type or Print)
a. (First): Maudie
b. (Middle): Pearl
c. (Last): Ayers

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1969

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 19, 1908
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Cook & Agriculture
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Stone County, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman Jenkins 21 — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 4 — (If yes, give war or dates of service): none 0
16. SOCIAL SECURITY NO.: 519-14-1422
17. INFORMANT'S OWN SIGNATURE: Lonnie Ayers — ADDRESS: Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adeno-Carcinoma c̄ Metastasis original left Breast — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Pleural Effusion Bilateral — May 1969

19a. DATE OF OPERATION: July 1968
19b. MAJOR FINDINGS OF OPERATION: Pleural Drainage Br Surgery
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-11-53, 19__ *to* 7-17-69, 19__, *that I last saw the deceased alive on* 7-17-69, 19__, *and that death occurred at* 3:25 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 526 (Degree or title) MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 19 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/21/69
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: July 28, 1969
REGISTRAR'S SIGNATURE: Bill H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Payne Mortuary

JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3238
Local Reg. No. 1994
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 28 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley, ----
c. LENGTH OF STAY (in this place): 50 Years 150
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 842 Conant Avenue 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 842 Conant Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Hannah
b. (Middle): Lorena
c. (Last): Prescott

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov.30,1895
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Liberty, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lorenzo Wixom, BIRTHPLACE: Paris, Idaho
14. MOTHER'S MAIDEN NAME: Lorena Maria Thompson, BIRTHPLACE: Jelstrup, Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 0 - - - -
16. SOCIAL SECURITY NO.: 519-22-3581
17. INFORMANT'S OWN SIGNATURE: Reta Thurston — ADDRESS: 1010 Occidental

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1990

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Anaplasic Carcinoma, primary site unknown — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease; Diabetes mellitus

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-12, 195, *to* 17 July, 1969, *that I last saw the deceased alive on* 7 July, 1969, *and that death occurred at* 9:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J B Richer 285 MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 18 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: July 21,1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Heyburn, Idaho

DATE REC'D BY LOCAL REG.: July 25 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: OCT 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 6 1969 Bureau of Vital Statistics

State File No. 3239
Local Reg. No. 2000
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
c. LENGTH OF STAY (In this place): 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ********** 206

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
d. STREET ADDRESS (If rural, give location): **********

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Moses	S	Martin	July 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Married	March 29, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher & stockraiser-Agriculture		Oakley (Basin) Idaho	U.S.A.

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
John G. Martin - Tooele, Utah	Mary Sagers - Tooele, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-42-5462	x Wm J Martin	Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Infarction	1 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized Arteriosclerosis	5 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Emphysema	5 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-11-57, 19__, *to* 7-18-69, 19__, *that I last saw the deceased alive on* 7-18-69, 19__, *and that death occurred at* 9:30 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Burley, Idaho	7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	7/21/69	Basin Cemetery	Oakley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 1 1969	Burt N. Pearson	[signature]	E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 8 1969

MAR 9 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3240
Local Reg. No. 1997
Reg. Dist. No. 470

BIRTH NO.

JUL 29 1969
Bureau of Vital

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 1 week 307
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1718 Burton Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Thomas 070
c. (Last): McCallister

4. DATE OF DEATH (Month) (Day) (Year): July 19, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: July 21, 1914
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Appliance & Furniture Store Owner
10b. KIND OF BUSINESS OR INDUSTRY: 22
11. BIRTHPLACE (State or foreign country): Boaz, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James L. McCallister — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Ada Johnson — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): none 0
16. SOCIAL SECURITY NO.: 518-09-3605
17. INFORMANT'S OWN SIGNATURE: John M McCallister — ADDRESS: Burley, Id.

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 8 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Coronary atherosclerosis ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: none

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1950, 19__, *to* 7-19-, 1969, *that I last saw the deceased alive on* 7-18-, 1969, *and that death occurred at* 1:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: R Hutton 514 (Degree or title) M D
23b. ADDRESS: Burley Ida
23c. DATE SIGNED: 7/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 7/22/69
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: July 28, 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Garth Sapp
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3241
Local Reg. No. 1999
Reg. Dist. No. 470

BIRTH NO.

RECEIVED JUL 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 61
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): Nine 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West 16th St. & Hiway 30

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Cassia 61
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 942 Schodde Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ralph	Stanley	Hodgson	July 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	Divorced 2	Nov. 4, 1941	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: *******
11. BIRTHPLACE (State or foreign country): White Pine Co., Nevada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME, BIRTHPLACE: Frank Stanley Hodgson-Durango, Colo.
14. MOTHER'S MAIDEN NAME, BIRTHPLACE: Ethel Alice Riffle-Durango, Colo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO. 508-52-8848
17. INFORMANT'S OWN SIGNATURE: Frank S Hodgson ADDRESS: Burley, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Head & internal Injuries ffom
ANTECEDENT CAUSES pedestrian, automobile accident.
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Burley Cassia 61 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 20, 6910:20 pm
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Pedestrian, automobile accident

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:21 m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Earl Young 583	Coroner 11	Burley, Idaho	7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/24/69	Pleasant View	Burley, Idaho

DATE REC'D BY LOCAL REG.: July 30 1969
REGISTRAR'S SIGNATURE: Buck A. Pearson
25. EMBALMER: [signature]
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3242
Local Reg. No. 2001
Reg. Dist. No. 470

RECEIVED AUG 8 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN: Oakley
c. LENGTH OF STAY (in this place): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): R.F.D.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grantsville
d. STREET ADDRESS (If rural, give location): *********

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Franklin		Mayo	July 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	Indian	Divorced	Unknown	44 (About)				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Agriculture	Ibapah, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Mayo	Unknown	Rosie Murphy	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 20	none	529-26-6232	Stella Blackner	Burley, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed chest & suffication — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Accidental pinning under hay loader
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Farm	Rural	Cassia 160	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒	NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
7	31	69	5:30 p.m.			

22. *I hereby certify that I attended the deceased from* About, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Bruce Young 583	Coroner 4	Burley, Idaho	8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal B	8/2/69	Skull Valley	Skull Valley, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 6 1969	Ruth H. Pearson		E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 30 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3243
Local Reg. No. 66
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Clark 170 AUG 6 1969

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 2 mi. west kilgore

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 mi west Kilgore 400

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Clark 170

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Kilgore

d. STREET ADDRESS (If rural, give location): 2 mi west

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRED	THEODORE	VADNAIS	July 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	Oct. 14, 1953	15				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	High School	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theodore Vadnais,	Idaho	Margaret McMillon	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 64 7808	X Theodore Vadnais	Kilgore, Ida

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	rural 78	Kilgore	Clark 170	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
July 17 1969 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Drown while swimming

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred Coroner	Dubois, Idaho	8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	July 17, 1969	Fielding Mem. Cem.	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-5-69			E387

FIRM NAME: Buck - Sullivan Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

State File No. 3244
Local Reg. No. 44
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN: Orofino
LENGTH OF STAY (in this place): 4 days 304
d. FULL NAME OF HOSPITAL OR INSTITUTION: Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN: Orofino
d. STREET ADDRESS (If rural, give location): 434 Brown Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Albert	Steffenson	July 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	married 3	Apr. 18, 1899	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
shovel operator	construction	Denver, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter L. Steffenson	Denmark	Clara Buhrl	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	564-10-8404	C. W. Steffenson	Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-29, 1969, *to* 7-3, 1969, *that I last saw the deceased alive on* 7-3, 1969, *and that death occurred at* 8:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert D. Hall, MD		7-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 7, 69	Rose City Cemetery	Portland, Multnomah, Ore.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 3, 1969	Josephine K. Hupp	Lyle A. Stettmann	476

Federal Security Agency
United States Public Health Service

Form DH-63021

FORM NAME: GILBERT'S FUNERAL CHAPEL

DUTIES:

JUL 2 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 2 7 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3245
Local Reg. No. 45
Reg. Dist. No. 210

RECEIVED JUL 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN Orofino
LENGTH OF STAY (in this place) 7 weeks 202

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater 180
c. CITY OR TOWN Orofino - rural

d. FULL NAME OF HOSPITAL OR INSTITUTION Clearwater Valley Hosp. 013
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	THOMAS	DUNN	July 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	married 2	Nov. 21, 1926	42				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Worker 06	constuction	New Madrid, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred L. Dunn	Ken.	Edel Jones	Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES / 1950-1953	490-24-6210	X Viola B. Dunn	Orofino, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Arrest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Carcinomatosis - Brain

DUE TO (c) Carcinoma, Rt Lung

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* July 8, 1969, *and that death occurred at* 6:50 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. L. McCumber 340 M.D.	Orofino Idaho	10 Jul 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 12, 69	Sikeston City Cemetery	Sikeston, Scott, Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Josephine K. Duff	Lyle A. Gilbert	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3246
Local Reg. No. 46
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater 180 — JUL 23 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino — LENGTH OF STAY (in this place) 28 days 328
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clearwater Valley Hosp. 013

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location) 732 Riverside Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JEANETTE	A.	GUSTON	July 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 2	Dec. 2, 1904	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
designer 25	florist	Orofino, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Miles L. Cochrane	Maine	Nessie D. Dunlap	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2 0	518-10-3920	Lyle C. Stutzman	Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	CARCINOMATOSIS OF THE ABDOMEN	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	ADENOCARCINOMA , COLON	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

1538

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JUNE, 1961, *to* JULY, 1969, *that I last saw the deceased alive on* 10 JULY, 1969, *and that death occurred at* 5:15P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 340 MD	Orofino Idaho	16 Jul 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 14, 69	Weseman	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 18, 1969	Lern M. Burger	Lyle C. Stutzman	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 2 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3247
Local Reg. No. 48
Reg. Dist. No. 210

RECEIVED JUL 23 1969

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bureau of Vital Statistics
c. LENGTH OF STAY (In hospital or institution): Minutes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Deary
d. STREET ADDRESS (If rural, give location): Rt. 1

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 60 Miles N. E. of Bovill, Ida.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Darrell	Baumgartner	July	11	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 5	July 19, 1907	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sawyer	Logging	Elberton, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Baumgartner	Harrison, Oregon	Nancy Stringfield	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		542-10-5714	Eldora Baumgartner	Park, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

916X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) broken neck — INTERVAL BETWEEN ONSET AND DEATH: sec.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	forest 12	Bovil, Clearwater, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
July 11, 69 10:00 a.m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	struck by falling tree

22. *I hereby certify that I attended the deceased from* ____ *19*____, *to* ____, *19*____, *that I last saw the deceased alive on* ____, *19*____, *and that death occurred at* 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
coroner	Orofino, Idaho	July 17, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 15, 1969	Garfield Cemetery	Garfield Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 18, 1969	Lera M. Burger	Donald Ward	E-80

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 5 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 18 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3248
Local Reg. No. 47
Reg. Dist. No. 210

Certificate of Death

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural
c. LENGTH OF STAY (in this place): sec. 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Highway 12 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): DOUGLAS
b. (Middle): NATHON
c. (Last): DENISON

4. DATE OF DEATH (Month) (Day) (Year): July 11, 1969

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married/
8. DATE OF BIRTH: Apr. 10, 1953
9. AGE (In years last birthday): 16 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Walla Walla, Wash.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Gilbert Denison — BIRTHPLACE: Wash.
14. MOTHER'S MAIDEN NAME: Dorothy Ann Jones — BIRTHPLACE: Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Gilbert M. Denison — ADDRESS: Weippe

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cr ushed skull, broken neck, internal injuries — INTERVAL BETWEEN ONSET AND DEATH: sec.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Fed. Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 180 **(COUNTY)** **(STATE)**: Orofino, Clearwater, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 11, 69 9:30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: auro accident

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 9:30p*m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title): Coroner
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: July 14, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: July 14, 69
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: July 14, 1969
REGISTRAR'S SIGNATURE: Josephine K. Duff
25. EMBALMER: Lyle A. Strottmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3249
Local Reg. No. 49
Reg. Dist. No. 210

RECEIVED JUL 23 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Orofino-rural
c. LENGTH OF STAY (in this place): sec.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Highway 12

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Richard Sam		Rosetti	July 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	never married	Jan. 1, 1949	20				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
woods worker 17	lumber	Iron River, Mich.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sam N. Rosetti	Mich.	Rose Mary Borski	Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	20		X Sam Rosetti	Weippe

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) crushed skull, internal injuries — INTERVAL BETWEEN ONSET AND DEATH: sec.

ANTECEDENT CAUSES — broken neck

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 180 (COUNTY) (STATE)
accident	Fed. Highway 06	Orofino, Clearwater, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
July 11, 69 9:30 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	auto accident

22. *I hereby certify that I attended the deceased from* ____ *19*____, *to* ____, *19*____, *that I last saw the deceased alive on* ____, *19*____, *and that death occurred at* 9:30p. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 585 (Coroner)	Orofino, Idaho	July 14, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 15, 1969	Weippe	Weippe, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 18, 1969	Fern M. Burger	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 9 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3250
Local Reg. No. 50
Reg. Dist. No. 210

BIRTH NO.

RECEIVED JUL 28 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino Rural
c. LENGTH OF STAY (in this place): 6 days 506
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THERESA	C.	ERICKSON	July 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed 2	Mar. 3, 1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife 01	own home	Petersburg, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew Mannlein	Germany	Theresa Grandler	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2 0		518-22-6903	X Allen Erickson	Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Acute Myocardial Infarction	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Duodenal Ulcer & Hemorrhage.	

4109

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Large duodenal ulcer post wall & severe Hemorrhage	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 14 Jul, 1969, *to* 20 Jul, 1969, *that I last saw the deceased alive on* 21 Jul, 1969, *and that death occurred at* 3:01 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 340 MD-1	Orofino, Idaho	21 Jul 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Jul. 22, 69	Lewis-Clark Mem. Gard.	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 22, 1969	Josephine K. Duff	Lyle A. Stallman	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3251
Local Reg. No. 51
Reg. Dist. No. 210

RECEIVED AUG 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 1½ days 30/
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MALINDA	B.	CARR	July 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F.	W.	Widowed 2	May 14, 1886	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife 07	own home	Lincoln, Neb.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Burr	Neb..	Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 0	518-16-2599	× George D Hopkins	Kamiah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

430X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-7, 1969, *to* 7-30, 1969, *that I last saw the deceased alive on* 7-30, 1969, *and that death occurred at* 9:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert E Hall M.D.	Northside Medical Route 3, Orofino, Idaho	8/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 4, 1969	Riverside	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 7, 1969	Vern M. Burger	Lyle A. Stratmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 29 1986

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3252
Local Reg. No. 52
Reg. Dist. No. 210

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY: Clearwater 30
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 4 days 30
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Vivian	Loretta	Wallace	July	31	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	April 24 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal worker 08
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Goverment
11. BIRTHPLACE (State or foreign country): Pacific Grove, Calif.
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: G. W. Towle — BIRTHPLACE: 1
14. MOTHER'S MAIDEN NAME: Marietta Towle — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no X
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 557 64 9176
17. INFORMANT'S OWN SIGNATURE: Ralph A Norton — ADDRESS: Kamiah, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4857

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia — 4 Days
DUE TO (c) Anemia — many years
Multiple Myeloma — many years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 28, 1969, *to* July 31, 1969 *that I last saw the deceased alive on* July 31, 1969, *and that death occurred at* 8:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD (Degree or title)
23b. ADDRESS: Kamiah, Ida
23c. DATE SIGNED: 8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 7 1969
24c. NAME OF CEMETERY OR CREMATORY: City
24d. LOCATION (City, town, or county) (State): Kamiah, Idaho

DATE REC'D BY LOCAL REG.: August 7, 1969
REGISTRAR'S SIGNATURE: Vern M. Burger
25. EMBALMER: [signature]
LICENSE NO.: E 421

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 3 0 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3253
Local Reg. No. 3
Reg. Dist. No. 680

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Custer 190
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Challis
c. LENGTH OF STAY (In this place): mins 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 8 mi. S. Highway 93 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 180 Park

3. NAME OF DECEASED (Type or Print)
a. (First): FRANCIS
b. (Middle): MICHAEL
c. (Last): PERN, JR.

4. DATE OF DEATH (Month) (Day) (Year): July 13, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 18, 1944
9. AGE (In years last birthday): 25 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Francis M. Pern, Sr. Butte, Montana
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Lavilla Gutzman Salmon, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): 1961-1965 7
16. SOCIAL SECURITY NO.: 467-72-7412
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Mrs. F. M. Pern Jr. Pocatello, Ida

8162

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Motorcycle Accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): U.S. 93 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Challis Custer 190 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 13 1969 7PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Thrown from motorcycle

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ralph Potter 583 Coroner
23b. ADDRESS: Challis Idaho
23c. DATE SIGNED: 7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7-18-69
24c. NAME OF CEMETERY OR CREMATORY: Mt. McCaleb Cemetery
24d. LOCATION (City, town, or county) (State): Mackay, Idaho

DATE REC'D BY LOCAL REG.: 7-19-69
REGISTRAR'S SIGNATURE: Pauline J. Mulder
25. EMBALMER: C. H. Marvel
LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 1 6 2006

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3254
Local Reg. No. 48
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Glenns Ferry
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3 miles East of Glenns Ferry 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: New Mexico 32
b. COUNTY: San Juan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ship Rock
d. STREET ADDRESS (If rural, give location): Ship Rock

3. NAME OF DECEASED (Type or Print)
a. (First): HERMAN
b. (Middle):
c. (Last): NEZ

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1969

5. SEX: Male
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 17, 1951
9. AGE (In years last birthday): 17 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Arizona
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dan Nez — BIRTHPLACE: New Mexico
14. MOTHER'S MAIDEN NAME: Julia Kelly — BIRTHPLACE: Arizona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Harry Lee — ADDRESS: Ship Rock, New Mex.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8161

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive skull fracture — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): auto accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): farm to market road 02
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Glenns Ferry, Elmore 200, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 2, 1969 8:00 PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Passenger in single car roll-over.

22. *I hereby certify that I attended the deceased from* Investigation only, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith 583 — (Degree or title): Coroner 4
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 7/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Transit
24b. DATE: 7/4/69
24c. NAME OF CEMETERY OR CREMATORY: Farmington, N. M.
24d. LOCATION (City, town, or county) (State): Farmington, New Mexico

DATE REC'D BY LOCAL REG.: July 8 1969
~~REGISTRAR'S SIGNATURE~~: [signature]
25. EMBALMER: H. Earl Humphreys — LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3255
Local Reg. No. 52
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED
AUG - 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Ohio 36
b. COUNTY: Lucas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Toledo
d. STREET ADDRESS (If rural, give location): 4775 296 Street

3. NAME OF DECEASED (Type or Print): a. (First) HARRY b. (Middle) LEWIS c. (Last) WEST

4. DATE OF DEATH: (Month) July (Day) 14, (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married S
8. DATE OF BIRTH: August 4, 1897
9. AGE (In years last birthday): 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY: Newspaper Delivery
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Amos West
BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Lou Ellen McGinnis
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 277-09-8591
17. INFORMANT'S OWN SIGNATURE: Mrs Elizabeth West
ADDRESS: Toledo, Ohio

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) rupture of aortic aneurism — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) hypertension
DUE TO (c) atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-13, 1969, to 7-14, 1969, that I last saw the deceased alive on 7-14, 1969, and that death occurred at 4:00 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): 583 Donna L Bell MD-4
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 7-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Toledo Cemetery
24d. LOCATION (City, town, or county) (State): Toledo, Ohio

DATE REC'D BY LOCAL REG.: July 28 69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H Neal Humphreys
LICENSE NO.: E-502
FIRM NAME: Smyth Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept 10, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3256
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Glenns Ferry 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
d. STREET ADDRESS (If rural, give location): Glenns Ferry

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	Wayne	Rutledge	July	17,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced 2	June 8, 1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer 10	Railroad	LaJara, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Anthony Rutledge	Colo.	Lenora Kathleen Hunt	Colo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0 None	518-05-8799	Mrs. Faye Williams	Anchorage, Alaska

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* investigation only, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur Smith, Coroner 583 4	Mountain Home, Idaho	7-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 22,1969	Little Butte	Annis, Jefferson, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 19,1969	Mary Sullivan	H. Neil Humphreys	E 502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amended An Original Certificate of Birth or Death

RECEIVED
SEP 9 1969
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death) for Joseph Wayne Rutledge (Name on Original Certificate) who died (Was Born or Died) on July 17, 1969 (Date of Event) in Glenns Ferry, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by Certificate of Baptism (Bible Record, Insurance Policy, Etc.) prepared on (5/11/21) May 11, 1921 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	June 8, 1904	June 8, 1906
Age	65	63
Social Security No.		518-05-8799

Subscribed and sworn to before me this 5th day of September, 1969

Thelma Mosdell

Notary Public, residing at Anchorage, Alaska

My commission expires 8-3-70

(Seal)

Signed Thelma L. McMillen

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Box 4-1669, Spenard, Anchorage, Alaska 99503

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Alaska } ss.
County of Anchorage }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 5th day of September, 1969

Notary Public, residing at Anchorage Alaska

My commission expires 8-3-70

(Seal)

Signed Faye A. Williams

(Signature of Any Credible Person)

3103 Eureka, Anch 99503

(Street Address, City, State)

FORM DH 60-155

NOTARY
PUBLIC
STATE OF ALASKA

NOTARY
PUBLIC
STATE OF ALASKA

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3256
Local Reg. No.
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
AUG 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Glenns Ferry

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
d. STREET ADDRESS (If rural, give location): Glenns Ferry

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOSEPH	WAYNE	RUTLEDGE	July 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	June 8, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer	Railroad	LaJara, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Anthony Rutledge	Colo.	Lenora Kathleen Hunt	Colo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None		Mrs Faye Williams	Anchorage, Alaska

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Investigation only, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur Smith Coroner	Mountain Home, Idaho	7/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 22, 1969	Little Butte	Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/3/1969	Mary Sullivan	A. Neil Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 10 1969

OCT 16 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3257
Local Reg. No. 54
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED AUG 12 1969 Bureau of

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 4 yrs / 04
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 895 N. 5th E.

3. NAME OF DECEASED (Type or Print): a. (First) FRANK b. (Middle) CHARLES c. (Last) HAMMAN

4. DATE OF DEATH: (Month) July (Day) 24, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Jan. 12, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk 25
10b. KIND OF BUSINESS OR INDUSTRY: Hotel Business
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Hamman — BIRTHPLACE: (NA)
14. MOTHER'S MAIDEN NAME: Finnie Bishop — BIRTHPLACE: (NA)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 530-20-1501
17. INFORMANT'S OWN SIGNATURE: Arthur Smith — ADDRESS: Mt. Home, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 2 yrs Arteriosclerotic myocardial insufficiency
DUE TO (c) 5 years Advanced Bronchodistress Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* July 24 '65 *to* July 24 '69, *that I last saw the deceased alive* July 24 '69, *and that death occurred at* 11:45 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ina Mae Woodcock MD — 23b. ADDRESS: Ina Mae Woodcock MD — 23c. DATE SIGNED: Aug 5, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 25, 1969	Mountain view Cem.	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Aug 5 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H Neil Humphreys
LICENSE NO.: E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3258
Local Reg. No. 53
Reg. Dist. No. 380 391

BIRTH NO.

AUG 12 1969
Bureau of Vital

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: San Bernadino
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): San Bernardino
d. STREET ADDRESS (If rural, give location): 3056 N. Golden Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): PATRICIA
b. (Middle): LYNN
c. (Last): GEARHEART

4. DATE OF DEATH (Month) (Day) (Year): July 27, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 24, 1951
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minor 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Donald Gearheart — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Marguerite R. Rodgers — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 554-82-9150
17. INFORMANT'S OWN SIGNATURE: Marguerite R. Gearheart — ADDRESS: San Bernardino, Cal.

18. CAUSE OF DEATH 8169
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shock and extreme blood loss — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Traumatic crushing and lacerations of pelvis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 30 06
21c. (CITY, TOWN, OR TOWNSHIP) 200 **(COUNTY)** **(STATE)**: Rural - Hammett, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7/27/69 3:00PM
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Single car accident, plunged off railway overpass

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation only *, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith 583 (Degree or title): Coroner 4
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 7/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: San Bernadino Cemetery
24d. LOCATION (City, town, or county) (State): San Bernadino California

DATE REC'D BY LOCAL REG.: Aug 5 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Neil Humphrey — LICENSE NO.: E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 1 1 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3259
Local Reg. No. 55
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 1210 Juniper

3. NAME OF DECEASED (Type or Print)
a. (First): F.
b. (Middle): ELBERT
c. (Last): HAWLEY

4. DATE OF DEATH (Month) (Day) (Year): July 28, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 9
8. DATE OF BIRTH: June 16, 1907
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: Educator
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles A. Hawley — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Myrtle Myers — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-14-8464
17. INFORMANT'S OWN SIGNATURE: Mrs. Elbert Hawley — ADDRESS: Mt. Home

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1966 July 28, 1969, *that I last saw the deceased alive on* July 25, 1969, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Malone W. Loebach, M.D.
23b. ADDRESS: Mountain Home Idaho
23c. DATE SIGNED: Aug 4, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 31, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county): Mountain Home — (State): Idaho

DATE REC'D BY LOCAL REG.: Aug 5 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Neil Humphrey
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECE

STATE OF IDAHO

State File No. 3260
Local Reg. No. 5 6
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200 AUG 12 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home — Bureau
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Mem. Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 515 N. 8th E.

3. NAME OF DECEASED (Type or Print)
a. (First): BARABRA
b. (Middle): CAMPBELL
c. (Last): CULLEN

4. DATE OF DEATH (Month) (Day) (Year): July 31, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 19, 1902
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Riddle Campbell — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Annabella Aiken — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 147-18-5808
17. INFORMANT'S OWN SIGNATURE: X William Cullen — ADDRESS: Mtn. Home

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4123 Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Severe Rheumatoid Arthritis years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 3, 1968 *to* July 31, 1969, *that I last saw the deceased alive on* July 30, 1969, *and that death occurred at* 1:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Malone W. Frebsch MD
23b. ADDRESS: Mountain Home Idaho
23c. DATE SIGNED: Aug 5 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home Idaho

DATE REC'D BY LOCAL REG.: Aug 5 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Verl Humphreys
LICENSE NO.: E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 18 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

DEC 21 1978

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

MAR 19 2012

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3261
Local Reg. No. 25
Reg. Dist. No. 540

RECEIVED JUL 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 22/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
LENGTH OF STAY (in this place): years 10
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): home S E of city 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 22/
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): SE of City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	Valate	Bawden Jensen	July 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Jan 22, 1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	own home	Ephraim, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William P. Bawden	Pilton Devon, England	Emma Jane Williams	Bristal, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 0	518 62 5207	Leon E. Jensen	Preston, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) ~~Arterio-sclerotic Heart Disease~~ — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Left Cerebro-Vascular Accident — 5 Mo's

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19 50, *to* July 5, 1969, *that I last saw the deceased alive on* 7/4/69, 19____, *and that death occurred at* 10.40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lee R. Harper	M.D.	Preston, Idaho	7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 9, 1969	Salt Lake City cemetery	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-9-69	Eyre W. Brower	O. Sherwin Webb	316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: WEBB FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3262
Local Reg. No. 1
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 22 JUL 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (In this place): life/00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 71 W 1 S 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 22
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 71 W 1 S

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HOWARD		HALL	July 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 8	July 14, 1894	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	sheep	Fairview, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Hill Hall	Wellsville, Utah	Henrietha Bronson	Willard, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW 1	519-34-0151	Elmore Hall	Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4367

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A. July 7. 1969 — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Prostatic Hypertrophy — 5 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 7, 1969, *to* July 7, 1969, *that I last saw the deceased alive on* July 7, 1969, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. R. Cutler	MD	Preston Idaho	7-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 10, 1969	Preston Cemetery	Preston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7.10.1969	Effie W. Brewer	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

JUL 2 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 4 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 5 1971

JAN 7 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 18 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3263
Local Reg. No. 2
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 22/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 5 WKS 32/
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial Hospital 08/

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 22/
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 514 E 1 S

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILLIAM	ALBERT	BECKSTEAD	July 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	married 3	Nov 24, 1891	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Coal & Feed 25	Retail	Whitney, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William A. Beckstead	So. Jordon, Utah	Josephine Foster	Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 20	518 09 8591 A	Gladys Beckstead	Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	30 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Cardiovascular Disease	4 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hypertensive Vascular Disease	24 hours

4123

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 14, 1969 *to* July 31, 1969, *that I last saw the deceased alive on* July 31, 1969, *and that death occurred at* 4 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. R. Cutler M.D.	Preston Idaho	7-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 30, 1969	Preston Cemetery	Preston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-30-69	Eppie W. Brower	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES: DEC 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 18 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3264
Local Reg. No. 3
Reg. Dist. No. 548

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 221
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 76 yrs / 76
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): CECELIA
c. (Last): JOHNSON CORBRIDGE

4. DATE OF DEATH (Month) (Day) (Year): July 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 21, 1892
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Preston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lorenzo Johnson — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Hansen — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Melvin J. Corbridge — ADDRESS: Preston, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis — 3 yrs

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 26, 1969, *to* July 28, 1969, *that I last saw the deceased alive on* July 28, 1969, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. R. Cutler 122 MD
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 7-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery
24d. LOCATION (City, town, or county) (State): Preston, Idaho

DATE REC'D BY LOCAL REG.: 7-30-69
REGISTRAR'S SIGNATURE: Effie W. Brower
25. EMBALMER: O. Sherwin Webb — LICENSE NO.: 316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3265
Local Reg. No. 4
Reg. Dist. No. 540

BIRTH NO.

RECEIVED
AUG 18 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Franklin 22/

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston

c. LENGTH OF STAY (in this place): 7 days 307

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial Hospital 08/

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Franklin 22/

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston

d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary Ann	Beckstead	Tanner	July 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	white	Married 3	Nov 8, 1892	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Whitney, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sidney Marcuis Beckstead	So Jordan, Ut	Lela Hull	Franklin, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2 8	519-44-2239	Leland R. Tanner	Salt Lake City, Utah

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) C-V-H — INTERVAL BETWEEN ONSET AND DEATH: Many

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22, 1969, *to* July 30, 1969, *that I last saw the deceased alive on* July 30, 1969, *and that death occurred at* 9:11 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. L. Cutler 22	MD/	Preston Idaho	7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 2, 1969	Whitney Cemetery	Whitney, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-2-69	Eyre W. Brower	Douglas S. Webb	488

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3266
Local Reg. No. 19
Reg. Dist. No. 651

Certificate of Death

RECEIVED
JUL 1 1 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chester
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chester
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): POLLY
b. (Middle): BROWN
c. (Last): POTTER

4. DATE OF DEATH (Month) (Day) (Year): July 1, 1969

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow 2
8. DATE OF BIRTH: 30 Nov 1887
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Teton Fremont County, Idaho
12. CITIZEN OF WHAT COUNTRY?: Usa

13. FATHER'S NAME: Joseph Brown — BIRTHPLACE: Springville, Utah
14. MOTHER'S MAIDEN NAME: Sara LaVina Clifford — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Donald Potter — ADDRESS: Chester, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 6 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1957, 19__, *to* July 1, 1969 *that I last saw the deceased alive on* May 12, 1969 *and that death occurred at* 7 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 2981
23b. ADDRESS: Ashton - Idaho
23c. DATE SIGNED: 7-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3 July 69
24c. NAME OF CEMETERY OR CREMATORY: Wilford Cemetery
24d. LOCATION (City, town, or county) (State): St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.: 5 July 69
REGISTRAR'S SIGNATURE: M D Hansen
25. EMBALMER: M. D. Hansen — M D Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen M m ri

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3267
Local Reg. No. 18
Reg. Dist. No. 650

BIRTH NO.

RECEIVED JUL 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Fremont 221
b. CITY OR TOWN St. Anthony
c. LENGTH OF STAY IN (city or town) (this place) 1 day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY Sacramento
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sacramento
d. STREET ADDRESS (If rural, give location) 6324 Welty Way

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CHARLES	JOSEPH	STETSON	July 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married 3	7 July 1895	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29		Oakland, California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin Stetson	Nebraska	Cecelia Salick	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No. 2 3	560-01-2482	Charles R Stetson	1420 Bryte Ave Sac

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Vascular Accident	6 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Paraplegia	25 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-30-69, 19___, *to* 7-1-69, 19___, *that I last saw the deceased alive on* 7-1-69, 19___, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard [illegible] MD	Stanton Idaho	7-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	3 July 69		Sacramento, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
3 July 69	M. D. Hansen	M. D. Hansen	E-354

FIRM NAME: Hansen Memorial Chape

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3268
Local Reg. No. 28
Reg. Dist. No. 651

RECEIVED JUL 11 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chester
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Family Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chester
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) JOSEPH; b. (Middle) AUSTIN; c. (Last) HOWARD

4. DATE OF DEATH: (Month) July (Day) 4 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 2
8. DATE OF BIRTH: March 28, 1917
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chester, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph S. Howard — BIRTHPLACE: Wilford, Idaho
14. MOTHER'S MAIDEN NAME: Venedia Monroe — BIRTHPLACE: Elsinore, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 2
16. SOCIAL SECURITY NO.: 519-09-5780
17. INFORMANT'S OWN SIGNATURE: Darell M. Howard — ADDRESS: 310 [illegible] Twin Falls Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* D.O.A. *, 19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at __ m., from the causes and on the date stated above.*

23a. SIGNATURE: Paul Lowell (Degree or title): 583 coroner
23b. ADDRESS: POB 170 St Anthony
23c. DATE SIGNED: 7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9 July 69
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 8 July 69
REGISTRAR'S SIGNATURE: M. D. Hansen
25. EMBALMER: M. D. Hansen
LICENSE NO.: E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 23 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3269
Local Reg. No. 35
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): life / 00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 084 his home at Marysville, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): rural area (Marysville)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RODNEY	VEACH	GIFFORD	July 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	Married 3	Jan 15, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	Agriculture	Marysville, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur Gifford	Weston, Idaho	Sara Jennie Bainbridge	Richmond, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	0 ---	518-58-8551	Rodney Paul Gifford	Ashton, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 10:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul Lowell 583	Coroner	Box 170, St. Anthony, Ida. 83445	7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 11, 1969	Pineview Cemetery	Ashton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
22 July 69	M. K. Hansen	Robert Bean	E-456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robert Bean Funeral Home

AUG 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3270
Local Reg. No. 34
Reg. Dist. No. 651

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Island Park
c. LENGTH OF STAY (in this place): Minutes 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Snake River 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route # 3 Sunnyside Road

3. NAME OF DECEASED (Type or Print)
a. (First): Delmer
b. (Middle): Edward
c. (Last): Simpson

4. DATE OF DEATH (Month) (Day) (Year): July 12 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 2, 1918
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner - Manager 22
10b. KIND OF BUSINESS OR INDUSTRY: Business Management
11. BIRTHPLACE (State or foreign country): Winter Quarters, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Henry Simpson — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Annie Elizabeth Knecht — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 528 09 1320
17. INFORMANT'S OWN SIGNATURE: Delmy J Simpson — ADDRESS: Griffith Indiana

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8309

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Suffocation

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Accidential Drowning
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Snake River
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Island Park, Fremont, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 12, 1969 7P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Canoe overturned in swift water throwning passengers in river

22. *I hereby certify that I attended the deceased from* D. O. A. *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul Romrell 583 Corner 4
23b. ADDRESS: POB 170 FREMONT St Anthony
23c. DATE SIGNED: 7-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7/17/69
24c. NAME OF CEMETERY OR CREMATORY: Salt Lake Cemetery
24d. LOCATION (City, town, or county) (State): Salt Lake City Utah

DATE REC'D BY LOCAL REG.: July 17-69
REGISTRAR'S SIGNATURE: M L Hansen
25. EMBALMER: Ralph M. Wood Ralph M Wood — LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 1 0 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 4 1989

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 0 4 2017

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3271
Local Reg. No. 26
Reg. Dist. No. 651

BIRTH NO.

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN: Newdale
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Family Home 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont, 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Newdale
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): BENJAMIN
b. (Middle): LeROY
c. (Last): BRIGGS

4. DATE OF DEATH: July 17, 1969

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower 2

8. DATE OF BIRTH: Jan., 21, 1896

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (State or foreign country): Teton, Fremont, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Briggs
BIRTHPLACE: Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME: Sarah Gillette
BIRTHPLACE: Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 518-32-4613

17. INFORMANT'S OWN SIGNATURE: Murray B. Briggs
ADDRESS: Newdale, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul Combs 583 Coroner
23b. ADDRESS: Box 170, St. Anthony, Ida. 83445
23c. DATE SIGNED: 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 21 July 69
24c. NAME OF CEMETERY OR CREMATORY: Teton-Newdale Cemetery
24d. LOCATION (City, town, or county) (State): Sugar City, Madison, Idaho

DATE REC'D BY LOCAL REG.: 22 July 69
REGISTRAR'S SIGNATURE: M. D. Hansen
25. EMBALMER: M. D. Hansen
LICENSE NO.: E-354
FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 2 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO
Bureau of Vital Statistics

State File No. 3272
Local Reg. No. 27
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): 2 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): none given

3. NAME OF DECEASED (Type or Print): a. (First) Lester b. (Middle) Ervin c. (Last) Dixon

4. DATE OF DEATH (Month) (Day) (Year): July 24, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 2

8. DATE OF BIRTH: June 8, 1911

9. AGE (In years last birthday): 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: varied

11. BIRTHPLACE (State or foreign country): Sarilda, near Ashton, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ellsworth Alfred Dixon
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Olive Blanche Nobel
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 518-20-3477

17. INFORMANT'S OWN SIGNATURE: Lester A. Dixon
ADDRESS: Salt Lake City, Ut

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic coronary heart disease — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4709

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24, 19 69, *to* _____, 19____, *that I last saw the deceased alive on* 7-24-, 19 69, *and that death occurred at* 10:2 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 2981
23b. ADDRESS: Ashton Idaho
23c. DATE SIGNED: 7-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 28, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: 1 Aug 69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAR 2 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3273
Local Reg. No. 28
Reg. Dist. No. 650

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 13 1969
Bureau of V.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 221 Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 628 West Main 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) 628 West Main

3. NAME OF DECEASED (Type or Print)
a. (First) ETHEL
b. (Middle) ROSE HAIGHT
c. (Last) WILDE LORDS

4. DATE OF DEATH (Month) (Day) (Year) July 29, 1969

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 22, 1920
9. AGE (In years last birthday) 49 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife and Waitress
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Spencer, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME 06 William Glen Haight — BIRTHPLACE Parker, Idaho
14. MOTHER'S MAIDEN NAME Annie Ella Smith — BIRTHPLACE Anaconda, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 519-20-9783
17. INFORMANT'S OWN SIGNATURE Irvin Lords — ADDRESS St. Anthony, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

340X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple Sclerosis — 20 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1962, *to* July 29, 1969, *that I last saw the deceased alive on* July 27, 1969, *and that death occurred at* 7:30 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE E. F. Soule 488 (Degree or title) MD
23b. ADDRESS St Anthony Idaho
23c. DATE SIGNED 8/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 4 Aug 69
REGISTRAR'S SIGNATURE M S Hansen
25. EMBALMER M S Hansen
LICENSE NO. E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 12 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3274
Local Reg. No. 30
Reg. Dist. No. 650

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 21 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 22 / Fremont
b. CITY OR TOWN St. Anthony (If outside corporate limits, write RURAL and give township) — LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chester
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Viola
b. (Middle) Vilate
c. (Last) Howard Birch

4. DATE OF DEATH (Month) (Day) (Year) July 30, 1969

5. SEX Female

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH Aug., 26, 1887

9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Wilford, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wm. Riley Howard Sr. — BIRTHPLACE Pleasant Grove, Utah

14. MOTHER'S MAIDEN NAME Elizabeth Jane Davis — BIRTHPLACE South Weber, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 509-05-8214A

17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS Chester, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

0539

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Herpes Zoster — 5 wks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1966, *to* July, 1969, *that I last saw the deceased alive on* July 30, 1969 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Lloyd Parrish MD — (Degree or title)

23b. ADDRESS St Anthony Ida

23c. DATE SIGNED 8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 4 August 69

24c. NAME OF CEMETERY OR CREMATORY Wilford Cemetery

24d. LOCATION (City, town, or county) St. Anthony, RFD#1, Idaho (State)

DATE REC'D BY LOCAL REG. 19 Aug 69

REGISTRAR'S SIGNATURE M. D. Hansen

25. EMBALMER M. D. Hansen

LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3275
Local Reg. No.
Reg. Dist. No. 340 341

Certificate of Death

RECEIVED
AUG 5 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Black Canyon Dam Reservoir 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri 26
b. COUNTY Saline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Marshall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Edward
b. (Middle) Lee
c. (Last) Mabrey

4. DATE OF DEATH (Month) (Day) (Year) July 23, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 2
8. DATE OF BIRTH Sept. 20, 1950
9. AGE (In years last birthday) 18 — IF UNDER 1 YEAR Months 10 Days 3 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor 06
10b. KIND OF BUSINESS OR INDUSTRY ----
11. BIRTHPLACE (State or foreign country) Marshall, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward Lincoln Mabrey — BIRTHPLACE Miami, Mo.
14. MOTHER'S MAIDEN NAME Catherine Brown — BIRTHPLACE Marshall Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1 — (If yes, give war or dates of service) 1-16-69 to 3-21-69
16. SOCIAL SECURITY NO. 550-74-1020
17. INFORMANT/STOWN SIGNATURE Catherine Mabrey — ADDRESS

9109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Submersion Drowning — INTERVAL BETWEEN ONSET AND DEATH —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE 1 (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) Gem (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I ~~attended~~ the deceased ~~from~~ necropsied on 7-29, 1969, to ~~, 19~~, ~~that I last saw the deceased alive on~~ ~~, 19~~, and that death occurred at ~~m.~~, from the causes and on the date stated above.*

23a. SIGNATURE [signature] 491 (Degree or title)
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 8-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 1
24b. DATE July 31, 1969
24c. NAME OF CEMETERY OR CREMATORY Emmett
24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. Aug 3 1969
REGISTRAR'S SIGNATURE Jean A Beatty
25. EMBALMER Walter Potter — LICENSE NO. E-445

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 27 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3276
Local Reg. No. 2
Reg. Dist. No. 340 341

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

AUG 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): 22 days 322
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Mem. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): So. Washington

3. NAME OF DECEASED (Type or Print)
a. (First): MATTIE
b. (Middle): E.
c. (Last): DILLON

4. DATE OF DEATH (Month) (Day) (Year): July 27, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Oct. 8, 1885
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 9, Days 19 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Davison — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Ellen Brock — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-10-0948
17. INFORMANT'S OWN SIGNATURE: Vera J. Leonard — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4122

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 21 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Hypertensive Cardiovascular disease — Unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-4-, 1955, *to* 7-27, 1969, *that I last saw the deceased alive on* 7-27, 1969, *and that death occurred at* 1:35 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harmon E. Holverson MD 241
23b. ADDRESS: Emmett, Idaho
23c. DATE SIGNED: 8-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 8-1-69
24c. NAME OF CEMETERY OR CREMATORY: Emmett Cemetery
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug. 2, 1969
REGISTRAR'S SIGNATURE: Jean A. Beatty
25. EMBALMER: Walter F. Potter
LICENSE NO.: E-445

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 9 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 09 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3277
Local Reg. No. 3
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
AUG 8 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem
b. CITY OR TOWN: Emmett
c. LENGTH OF STAY (in this place): 3 1/2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION: Rt. 2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah
b. COUNTY: Salt Lake Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salt Lake City
d. STREET ADDRESS (If rural, give location): 1280 E. So. Temple

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Yale	Jay	VreNon	July 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	never married	Dec 26, 1966	2	7	5		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
child	----	Ogden, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Monte VreNon	Reno, Nevada	Karen Jensen	Coalville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	None	X Karen J VreNon	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at about* 6p m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. Goodwin MD (Degree or title)
23b. ADDRESS: Emmett, Ida
23c. DATE SIGNED: 4 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug 5, 1969
REGISTRAR'S SIGNATURE: Jean A Beatty
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3278
Local Reg. No. 3157
Reg. Dist. No. 420

BIRTH NO.

RECEIVED JUL 10 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Gooding 240

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural--Gooding

c. LENGTH OF STAY (In this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4-East & 1½ Miles North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Gooding 240

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding

d. STREET ADDRESS (If rural, give location): Route #2 4 Miles East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	Charles	Bohannon	July 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Never Married	Aug. 20, 1953	15	10 / 16	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Student 03	Education	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles J. Bohannon	Missouri	Lois L. Wilder	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	←	519-64-2700	Records of Thompson Chapel-Gooding	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Suffocation — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / ~~SUICIDE~~ HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 240	(COUNTY)	(STATE)
Accident-	4-E. & 1½ Miles North	Gooding	Gooding,	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
July 6, 1969 8:45P m.		One car roll over on country road

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* July 6, 19 69, *that I last saw the deceased alive on* Did not see alive, *and that death occurred at* 8:45PM m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Gooding, Idaho	7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	7-9-1969	Canyon Hill Cemetery	Caldwell,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-July-69	Eddie Leach	Eddie Leach	E-511

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

JUL 1 1 1969
JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
SEP 25 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
MAY 25 1978
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3279
Local Reg. No. 3158
Reg. Dist. No. 420

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (In this place): 5 days 805
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State T.B. & Chest D. Hosp. 091

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 934 Conant.

3. NAME OF DECEASED (Type or Print)
a. (First): Maude
b. (Middle): E
c. (Last): Badger

4. DATE OF DEATH (Month) (Day) (Year): 7 20 69

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 9-26-1886
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Hooper Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Henry Priest — BIRTHPLACE: Hooper Utah
14. MOTHER'S MAIDEN NAME: Margaret E. Stokes — BIRTHPLACE: Hooper, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 3
16. SOCIAL SECURITY NO.: 519-34-6308B
17. INFORMANT'S OWN SIGNATURE: K.A. Tyler MD — ADDRESS: IT.B.H. Gooding

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic Pneumonitis - possibly Tuberculous.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-15, 1969, *to* 7-20, 1969, *that I last saw the deceased alive on* 7-20, 1969, *and that death occurred at* 9:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K.A. Tyler MD 598
23b. ADDRESS: Gooding, Idaho — Idaho T.B. & Chest Disease Hosp.
23c. DATE SIGNED: 7/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Deweyville Cemetery
24d. LOCATION (City, town, or county) (State): Deweyville, Utah

DATE REC'D BY LOCAL REG.: 22 July 69
REGISTRAR'S SIGNATURE: Edd G. Lynch
25. EMBALMER: Jerry K. Lawson — LICENSE NO.: E-522
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Sheet

Certificate of Death
STATE OF IDAHO

State File No. 3280
Local Reg. No. 3159
Reg. Dist. No. 420

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
c. LENGTH OF STAY (In this place): 8½ yrs. / 104
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Manor 053

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 104 Montana St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Floetta	----	Wright	July 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years if under 1 birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	Feb. 28, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Yakima, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Everett Miller	Unknown	Ina Bell Piekew	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-------	518-66-7376	X Records, Magic Valley Manor-Wendell	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Disseminated carcinomatosis	2 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	CA of uterus	2 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

1829

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 1967 *to* 24 Jul 1969 *that I last saw the deceased alive on* 24 July 1969 *and that death occurred at* 2:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard [illegible] MD	Rexburg Idaho	28 Jul 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-28-1969	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 29, 1969	Eddie D. Leach	Eddie D. Leach	E-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3281
Local Reg. No. 3160
Reg. Dist. No. 420

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (In this place): 4-days 524
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding County Memorial Hospital 059

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glennsferry
d. STREET ADDRESS (If rural, give location): P.O. Box 266

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ada	Mary	Arnold	July 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	Jan. 7, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Wilson	Unknown	Daniels	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no -------	518-54-0871	Rupert A Arnold	Gooding, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION — 5320

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pulmonary Embolism, bilateral	5 Day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Duodenal Ulcer with hemorrhage	
DUE TO (c)	& aspiration of contents.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Obesity marked, oxygenum	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21-69, 19____, *to* 7-25-69, 19____, *that I last saw the deceased alive on* July 25-69, 19____, *and that death occurred at* 8:15 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
285 Marvin V. Slaughter MD	Gooding, Idaho	7-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 29, 1969	Glenn Rest Cemetery	Glennsferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jul 29-1969	Eddie A Leach	Eddie A Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Klingler

Certificate of Death
STATE OF IDAHO

State File No. 3282
Local Reg. No. 3161
Reg. Dist. No. 420

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding 240
d. STREET ADDRESS (If rural, give location) 345 Nevada St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Wesley	Miller	July 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed 2	Jan. 13, 1875	94		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Minister 18	Retired	near Stouffville, Canada	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Noah E. Miller	Ireland	Suzanne Piper	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-------	519-38-0152	John W Miller	Gooding

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 7963 Natural Causes incidental to age of 94

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1952, 19__, *to* July 27, 19 69, *that I last saw the deceased alive on* June 1, 1969, 19__ *and that death occurred at* 3:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marion O Klingler 285	Gooding, Idaho	July 28, '69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-30-1969	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 29, 1969	Eddie D. Leach	Fred J Nelson	E-504

FIRM NAME Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 1969

OCT 12 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3283
Local Reg. No. 15
Reg. Dist. No. 242

RECEIVED AUG 15 1969 Bureau of Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Susan
b. (Middle):
c. (Last): Hoene

4. DATE OF DEATH (Month) May (Day) 22 (Year) 69

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 4 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. John, Wisconsin
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: George Seubert — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Elizabeth Kees — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 36 7960
17. INFORMANT'S OWN SIGNATURE: August Hoene — ADDRESS: Cottonwood, Ida

18. CAUSE OF DEATH 2509
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Exsanguinating gastro-intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) AS generalized

DUE TO (c) Diabetes

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec., 1968, *to* May 22, 1969, *that I last saw the deceased alive on* May 22, 1969, *and that death occurred at* 2:50 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 398 Richard E. Orr, M.D.
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: 7/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May 24 69
24c. NAME OF CEMETERY OR CREMATORY: Catholic
24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: July 23, 1969
REGISTRAR'S SIGNATURE: Wesley F. Orr, M.D. by [illegible]
25. EMBALMER: Clifton Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3284
Local Reg. No. 792
Reg. Dist. No. 244

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

1. PLACE OF DEATH
a. COUNTY Idaho 250 JUL 7 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kooskia
c. LENGTH OF STAY (in this place) 57 yrs/57
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1/2 Mile E. in Clearwater river 400

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kooskia
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Lloyd
b. (Middle) Lester
c. (Last) Brown

4. DATE OF DEATH (Month) July (Day) 2 (Year) 1969

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4
8. DATE OF BIRTH Sept. 4, 1911
9. AGE (In years last birthday) 57 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodsman 17
10b. KIND OF BUSINESS OR INDUSTRY Logging
11. BIRTHPLACE (State or foreign country) Kooskia Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ansgar Brown BIRTHPLACE Brokenbow Nebraska
14. MOTHER'S MAIDEN NAME Clara E Wren BIRTHPLACE Cottonwood, Idaho.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes / (If yes, give war or dates of service) 3 WW II 8160
16. SOCIAL SECURITY NO. 518-14-6166
17. INFORMANT'S OWN SIGNATURE Ralph Brown ADDRESS Kooskia, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Apparent Drowning
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Clearwater River
21c. (CITY, TOWN, OR TOWNSHIP) 1/2 Mile East-Kooskia (COUNTY) Idaho (STATE) Idaho

21d. TIME OF INJURY (Month) 7 (Day) 2 (Year) 69 (Hour) 1:30 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Prove Vehicle into River

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE J. R. Smith 588 (Degree or title) Justice of Shepard
23b. ADDRESS Box 416 Kooskia, Idaho
23c. DATE SIGNED 7/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 5 1969
24c. NAME OF CEMETERY OR CREMATORY Tahoe Cem
24d. LOCATION (City, town, or county) Kooskia Idaho (State) Idaho

DATE REC'D BY LOCAL REG. 7/2/69
REGISTRAR'S SIGNATURE Claude Trenary
25. EMBALMER Arthur Ashlorn
LICENSE NO. E421

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Trenary Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 22 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3285
Local Reg. No. 16
Reg. Dist. No. 242

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 1 5 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood Bureau of Vital
c. LENGTH OF STAY (in this place): 1 month 201
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Gertrude's Convent
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sr. Mary
b. (Middle): Eugenia
c. (Last): Schallberger

4. DATE OF DEATH (Month) July (Day) 2 (Year) 69

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married /
8. DATE OF BIRTH: Aug 1 1885
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): religious nun 18
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lungern, Switzerland
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME — BIRTHPLACE: Joseph F. Schallberger
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Marie A. Vogler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-60-5117 65
17. INFORMANT'S OWN SIGNATURE: Sister M Martina — ADDRESS: Cottonwood, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pancreatic cyst & common bile duct obstruction

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Carcinoma of pancreas, most likely
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: A.S.H.D.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1969, *to* July 2, 1969, *that I last saw the deceased alive on* July 2, 1969, *and that death occurred at* 6:50 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 398 Richard E. Orr M.D.
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: 7-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 5, 69
24c. NAME OF CEMETERY OR CREMATORY: St. Gertrude's
24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: July 5, 1969
REGISTRAR'S SIGNATURE: Wesley F. Orr M.D. by M
25. EMBALMER: Peter A. Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Homes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

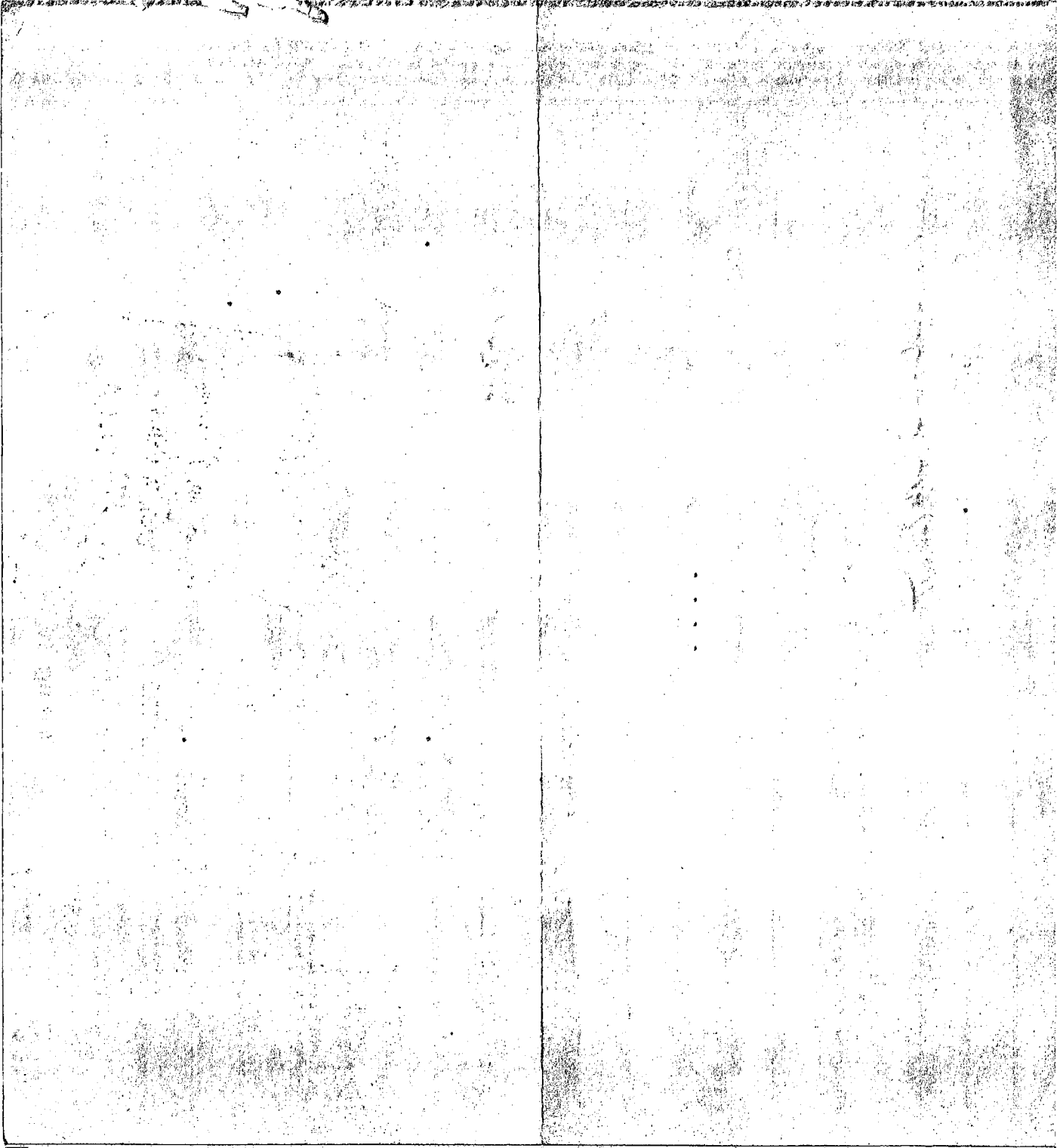

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3286
Local Reg. No. 45
Reg. Dist. No. 240

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics JUL 16 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 4½ hrs. 05
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hosp. 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elk City
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Floyd	Fleming	Graham	July	5,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	Widowed 2	Sept. 25, 1903	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Switch man	Rail Road	Trout Lake, British Columbia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fleming S. Graham	Bowling Green Kentucky	Margaret E. Jackson	Princeton, Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	430-24-0024	Floyd Jones	Elk City Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis — few years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of prostate with metastasis — 2-3 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/28, 1969, *to* 5 July, 1969, *that I last saw the deceased alive on* 4 July, 1969, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Weltman	M.D.	Grangeville, Idaho	11 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY ~~OR CREMATORY~~	24d. LOCATION (City, town, or county) (State)
Burial	July 8 1969	Pine Grove	Kooskia Idaho Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 12, 1969	Irma Cone	Robert R Hanna	E 403

FIRM NAME: Irenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 11 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3287
Local Reg. No. 17
Reg. Dist. No. 242

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

AUG 15 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF [illegible] (in this place): 1 day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood rural
d. STREET ADDRESS (If rural, give location): 8 miles south

3. NAME OF DECEASED (Type or Print)
a. (First): Roy
b. (Middle):
c. (Last): Murdick

4. DATE OF DEATH (Month) July (Day) 9 (Year) 69

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Jan 5 1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Cattle
11. BIRTHPLACE (State or foreign country): Omaha Nebraska
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: John Murdick — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Emma C. Potter — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes 1 — (If yes, give war or dates of service): 1918 WWW1 3
16. SOCIAL SECURITY NO.: 519 22 6798 A
17. INFORMANT'S OWN SIGNATURE: Mrs Elmer Taylor — ADDRESS: Cottonwood

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Urinary infection — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
also ~~DUE~~ TO (b) Chronic Bronchitis - asthma emphysema — 50 yrs.
also ~~DUE~~ TO (c) Congestive heart failure — 4-7 days.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diarrhea — 1 day.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 9, 1969, *to* July 9, 1969, *that I last saw the deceased alive on* July 9, 1969, *and that death occurred at* 10:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William J. Greenwood 189 MD
23b. ADDRESS: Grangeville Idaho
23c. DATE SIGNED: 7-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 13, 69
24c. NAME OF CEMETERY OR CREMATORY: Community
24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: 7/11/69
REGISTRAR'S SIGNATURE: Wesley F. Orr, MD
25. EMBALMER: Clifton Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

AUG 15 1969

Certificate of Death

STATE OF IDAHO

State File No. 3288
Local Reg. No. 47
Reg. Dist. No. 240

RECEIVED JUL 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 5 days 803
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville, General Hosp. 02

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 815 South A

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HERMINA	TENA	LUCAS	July 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	April 3, 1920	49				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Grangeville, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Scholtens	Holland	Alice Vanderwall	Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	536 20 8766	x Henry Lucas	Grangeville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 203X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1960, *to* July 14, 1969, *that I last saw the deceased alive on* July 14, 1969, *and that death occurred at* 10:20 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm Mannion MD M. D.	Grangeville, Id	7/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/19/69	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 22, 1969	Irma Cone	Robert R Hansen Robert R Hansen	E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 6 1991

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3289
Local Reg. No. 46
Reg. Dist. No. 240

RECEIVED JUL 18 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 6 mo. 20
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Box 315

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GARY	LEE	STEPHENS	July 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married S	January 13, 1941	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Logger 17	Logging	Winchester, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joe Stephens	Agatha, Idaho	Hazel Denny	Fletcher, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-42-4099	Lila Stephens	Grangeville, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushing Injuries of Head & Chest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
X	Silver Creek	20 Miles East Grangeville 13 250 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
July 14 69 9AM	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Logging Accident Boom Fell

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 4	IDAHO COUNTY CORONER	15 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 17, 1969	Lewis and Clark Memorial Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 15, 1969	Irma Cone	Robert R. Hansen	E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3290
Local Reg. No. 48
Reg. Dist. No. 240

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 21 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Golden
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 Miles West of Golden on HiWay 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Star Route

3. NAME OF DECEASED (Type or Print)
a. (First): DONALD
b. (Middle): LEE
c. (Last): WEHOLT

4. DATE OF DEATH (Month) (Day) (Year): 20 July 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3 April 1932
9. AGE (In years last birthday): 37 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance 06
10b. KIND OF BUSINESS OR INDUSTRY: HiWay, State
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Selmer Weholt — BIRTHPLACE: Genesee, Ida.
14. MOTHER'S MAIDEN NAME: Flossie Ferguson — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES 1 — (If yes, give war or dates of service): Korean 6
16. SOCIAL SECURITY NO.: 519 32 9832
17. INFORMANT'S OWN SIGNATURE: X Lorraine Dixie Weholt — ADDRESS: Grangeville, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

928X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushing injuries of Chest

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE X (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 20 69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Arm from bucket loader fell

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 8:30 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 583
23b. ADDRESS: IDAHO COUNTY CORONER
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal/Burial
24b. DATE: Burial 24 July 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, NezPerce Co., Ida

DATE REC'D BY LOCAL REG.: July 28 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Cecil R. Uhlorn
LICENSE NO.: E-421.

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3291
Local Reg. No. 50
Reg. Dist. No. 240

Certificate of Death

RECEIVED
AUG 7 1969
Bureau of Vital

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 4 yrs 104
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho County Nursing Home 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riggins
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Grace
b. (Middle): F.
c. (Last): Ruark

4. DATE OF DEATH (Month) July (Day) 24 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Feb 10 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook & Waiter 06
10b. KIND OF BUSINESS OR INDUSTRY: Restruant
11. BIRTHPLACE (State or foreign country): Pullman, Wash
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: L. B. Murphy — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Beatrice Howard — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 22 4604 A
17. INFORMANT'S OWN SIGNATURE: Mrs Al Court — ADDRESS: Grangeville Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Neurotoxic arthritis — INTERVAL BETWEEN ONSET AND DEATH: Several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) & Cachexia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 28 Apr., 1969, *to* 29 July, 1969, *that I last saw the deceased alive on* 29 July, 1969, *and that death occurred at* 11:57 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald Saltman M.D. 487
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 30 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 26 69
24c. NAME OF CEMETERY OR CREMATORY: Prairie View
24d. LOCATION (City, town, or county) (State): Grangeville Idaho

DATE REC'D BY LOCAL REG.: Aug 5, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Clifford Ashlorn
LICENSE NO.: E 421

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3292
Local Reg. No. 49
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Idaho 250 — AUG 7 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 2 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hosp. 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — a. STATE: Idaho — b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia
d. STREET ADDRESS (If rural, give location): 1 mile South

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Pearl	Ann	Talbott	July 28 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	white	married	July 17, 1881	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wife - Mother	on Farm home	Dayton, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Morrison McMillan	Unk.	Lucinda Melott	Morrow County, Ohio.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-42-2833B	Leon Samuel	Kooskia Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro vasc. hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertension and — several years

DUE TO (c) atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* on 28 July, 19 69, to _____, 19____, *that I last saw the deceased alive on* 28 July, 1969, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Saltman M.D.	Grangeville, Idaho	31 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 30, 1969	Lewis-Clark Gardens	Lewiston Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 4 1969	Irma Cone	Clifford Nelson	E431

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: NOV 1 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3293 (3293)
Local Reg. No. 52
Reg. Dist. No. 240

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 13 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 420 North Hall

3. NAME OF DECEASED (Type or Print): a. (First) Maggie; b. (Middle) L.; c. (Last) Robinette

4. DATE OF DEATH: July (Month) 29, (Day) 1969 (Year)

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: April 18, 1926

9. AGE (In years last birthday): 43 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Scott County Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: I. C. Maness — BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Ollie Fisher — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 227-28-4879

17. INFORMANT'S OWN SIGNATURE: John E Robinette — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8160

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apparent Drowning — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): /

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 18

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): East of Grangeville Ida Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 29 69 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Drove into River at South Fork of Clearwater

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): IDAHO COUNTY CORONER — **23b. ADDRESS**: / — **23c. DATE SIGNED**: 14 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3 — **24b. DATE**: July 30, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Robinette Funeral Home — **24d. LOCATION** (City, town, or county) (State): Blackwater Virginia

DATE REC'D BY LOCAL REG.: Aug 14 1969 — **REGISTRAR'S SIGNATURE**: Irma Cone

25. EMBALMER: Curtis Nicholson — **LICENSE NO.**: E 421

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3294
Local Reg. No. 9
Reg. Dist. No. 640

RECEIVED
AUG - 4 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jefferson 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Terreton
c. LENGTH OF STAY IN (this place): min. 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 Mi. N. of Sage Junction

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Nevada 29
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sparks
d. STREET ADDRESS (If rural, give location): 1978 Frazer Street

3. NAME OF DECEASED (Type or Print): a. (First) Marjorie; b. (Middle) Corin; c. (Last) Trumbo

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 5, 1924

9. AGE (In years last birthday): 44
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Seattle, Washington

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Waco Foster
BIRTHPLACE: Wash.

14. MOTHER'S MAIDEN NAME: Nellie Dixon
BIRTHPLACE: Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 229-16-1324

17. INFORMANT'S OWN SIGNATURE: Carl C Van Wey
Carl C. Van Wey
ADDRESS: 325 Bluesprings Ln Oceanside, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 8139 Massive skull fracture facial area
INTERVAL BETWEEN ONSET AND DEATH: min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Automobile accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture Lt. Femur

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Terreton Jefferson 240 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 2, 1969 P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Car struck parked highway roller.

22. *I hereby certify that I attended the deceased from* [illegible] *last saw the deceased alive on* [illegible] *and that death occurred at* 10:35 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Norman [illegible] (Degree or title): Coroner
23b. ADDRESS: Rigby, Idaho.
23c. DATE SIGNED: 7/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Eternal Hills
24d. LOCATION (City, town, or county) (State): Oceanside, California

DATE REC'D BY LOCAL REG.: 7/6/69
REGISTRAR'S SIGNATURE: Mrs A B Eckersell

25. EMBALMER: Bruce A. Eckersell
LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3295
Local Reg. No.
Reg. Dist. No. 64-2

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
c. LENGTH OF STAY (in this place): 71 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route#1: 1 mile E.of Rigby

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 26
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LOYAL	MATHEW	MADSEN	July 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	12/10/97	71	6	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Line Man
10b. KIND OF BUSINESS OR INDUSTRY: Electical
11. BIRTHPLACE (State or foreign country): Rigby, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hans Peter Madsen — BIRTHPLACE: Salt Lake Utah
14. MOTHER'S MAIDEN NAME: Edith Robbins — BIRTHPLACE: Willard Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 518-0932-04
17. INFORMANT'S OWN SIGNATURE: Loyal Madsen — ADDRESS: Rigby, Idaho.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — year
DUE TO (c): Emphysema + Cor Pulmonare — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: None performed
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 March, 1953 *to* 5 July, 1969, *that I last saw the deceased alive on* July 5, 1969, *and that death occurred at* 5:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Hall 522 (Degree or title) M.D.
23b. ADDRESS: Rigby, Idaho
23c. DATE SIGNED: 7 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/8/69
24c. NAME OF CEMETERY OR CREMATORY: Rigby Pioneer
24d. LOCATION (City, town, or county) (State): Rigby Idaho

DATE REC'D BY LOCAL REG.: 7/8/69
REGISTRAR'S SIGNATURE: Mrs. A. B. Eckersell
25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404
FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3296
Local Reg. No. 3
Reg. Dist. No. 640

Certificate of Death

RECEIVED
AUG - 4 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Terreton
c. LENGTH OF STAY (In this place): 0-0-0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 3/4 mi So. West Terreton 0-0-0

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Terreton
d. STREET ADDRESS (If rural, give location): 1 3/4 Mi So. West Terreton, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): THOMAS
b. (Middle): MICHAEL
c. (Last): HODGSON

4. DATE OF DEATH (Month) (Day) (Year): July 16, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: March 22, 1968
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 15 Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Arthur Hodgson, BIRTHPLACE: Washington
14. MOTHER'S MAIDEN NAME: Annette Jackett, BIRTHPLACE: Idaho Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: &None
17. INFORMANT'S OWN SIGNATURE: Tom A. Hodgson, ADDRESS: Terreton Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm 02
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Terreton Jefferson 260 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 15 1969 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Fell in irrigation ditch

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 9:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Norman Hall 583 (Degree or title): Coroner
23b. ADDRESS: Rigby, Idaho
23c. DATE SIGNED: July 25,69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Cem.
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: 7/25/69
REGISTRAR'S SIGNATURE: Mrs A B Eckersell
25. EMBALMER: Buck Sullivan
LICENSE NO.: E387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 2 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3297
Local Reg. No. 4
Reg. Dist. No. 640

RECEIVED
AUG - 4 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
c. LENGTH OF STAY (In this place): years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rte. #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): Rte. #2

3. NAME OF DECEASED (Type or Print): a. (First) KENNETH b. (Middle) c. (Last) MORGAN

4. DATE OF DEATH (Month) (Day) (Year): July 22, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 28, 1904

9. AGE (In years last birthday): 63 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Neeley, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas William Morgan — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Lovina Ross — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-10-2327

17. INFORMANT'S OWN SIGNATURE: Mary I. Morgan — ADDRESS: Rte. #2 Rigby, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed Chest — INTERVAL BETWEEN ONSET AND DEATH: inst.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Tractor accident.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rigby Jefferson 260 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 22, 1969 8 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Tractor rolled over into canal.

22. *I hereby certify that I attended the deceased from* XXXXXXXXXX *to* XXXXXXXXXX, *that I last saw the deceased alive on* XXXXXXXXXX, *that death occurred at* 8:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Vernon Hall coroner

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: 7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 25, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pioneer

24d. LOCATION (City, town, or county) (State): Rigby Jefferson Idaho

DATE REC'D BY LOCAL REG.: 7/25/69

REGISTRAR'S SIGNATURE: Myrl B. Eckersell

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3298
Local Reg. No. 1227
Reg. Dist. No. 440

BIRTH NO. RECEIVED STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270 — JUL 10 1969
b. CITY OR TOWN: Jerome — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): D-C
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Benedict's Hospital 089

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN: Jerome 83338
d. STREET ADDRESS (If rural, give location): 313 East Ave. "D"

3. NAME OF DECEASED (Type or Print)
a. (First): JULIA
b. (Middle): KATE
c. (Last): JACOBS

4. DATE OF DEATH: July 2, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 19, 1893

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Limeston, Tennessee

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Depew
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Eliza Squibb
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-34-7113

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Twin Falls, Idaho
Mrs. C. F. (Miriam) Depew

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5770

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Phlebothrombosis~~ Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Phlebothrombosis (Inferior) abd V. Cava. — 30 ds ?

DUE TO (c) acute pancreatitis — 2 wks.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-19-69, 19___, *to* 7-2, 1969, *that I last saw the deceased alive on* 7-1, 1969, *and that death occurred at* 5:10A m., *from the causes and on the date stated above.*

23a. SIGNATURE AND (Degree or title): Reuben C. Matson MD 330

23b. ADDRESS: Jerome Ida

23c. DATE SIGNED: 7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July5, 1969

24c. NAME OF CEMETERY OR CREMATORY: Wendell Cemetery

24d. LOCATION (City, town, or county) (State): Wendell Idaho

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE: Louella M. Scherer

25. EMBALMER: W. L. Hove

LICENSE NO.: E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 8 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3299
Local Reg. No. 1228
Reg. Dist. No. 440

Certificate of Death

RECEIVED JUL 10 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 089

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 229 East Ave. "I"

3. NAME OF DECEASED (Type or Print)
a. (First) ARNO
b. (Middle)
c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year) July 4, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 2, 1885
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Hartville, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Nathan Johnson — BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Nancy Stigall — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 519 22 2958
17. INFORMANT'S OWN SIGNATURE * Mrs Vada E Johnson — ADDRESS Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cerebral hemorrhage — 3 wks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-15, 1969, *to* 7-4, 1969, *that I last saw the deceased alive on* 7-2, 1969, *and that death occurred at* 3:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Reuben C. Matson MD 336 (Degree or title)
23b. ADDRESS Jerome Ida.
23c. DATE SIGNED 7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 8, 1969
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAR 6 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

State File No. 3300
Local Reg. No. 1229
Reg. Dist. No. 440

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38:206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (In this place) DOA 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA St. Benedicts Hosp. 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) 83338
d. STREET ADDRESS (If rural, give location) Route # 2 (4 mil. West)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MIRIAM	RACHEL	EGBERT	July 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	never married	April 17, 1968	1	2	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
infant 02		Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edwin Egbert	Idaho	Eileen Johnson	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no - - - - - -	none	X Edwin Egbert	Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 3-5 minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Drowning — 3-5 minutes
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident	home 01	Jerome	Jerome 270	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
July 6, 1969 3:00 p.m.		Child fell into irrigation ditch

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* approx 3:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jan D. Wilmoth, M.D.	Jerome, Idaho 216 E. Main	July 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	7-9-69	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 11 1969	Louella M. Schurer	Dale O Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3301
Local Reg. No. 1230
Reg. Dist. No. 440

RECEIVED Certificate of Death

STATE OF IDAHO

BIRTH NO. JUL 30 1969

1. PLACE OF DEATH
a. COUNTY Jerome 270 Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 83338 Jerome (rural)
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hwy 80, ½ mi. East of #50 interchange 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri 26
b. COUNTY Jackson 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
d. STREET ADDRESS (If rural, give location) 5434 Forest

3. NAME OF DECEASED (Type or Print)
a. (First) JACK
b. (Middle) LOREN
c. (Last) TEAGUE

4. DATE OF DEATH (Month) (Day) (Year) July 24, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH July 23, 1935
9. AGE (In years last birthday) 34 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist 21
10b. KIND OF BUSINESS OR INDUSTRY not known
11. BIRTHPLACE (State or foreign country) Mt. Vernon, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Teague — BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Modest Pearl Hollenbaugh — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 541 38 4855
17. INFORMANT'S OWN SIGNATURE X Melvin Lloyd Hunt — ADDRESS Grandview, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture neck — INTERVAL BETWEEN ONSET AND DEATH none

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident
21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) Freeway near Eden
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) Jerome 270 (STATE) Ida.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7 24 69 6:30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Left rode & rolled

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 6:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE [illegible] 583 (Degree or title) Coroner 4
23b. ADDRESS Jerome Ida
23c. DATE SIGNED 26 Jul 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 28, 1969
24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery
24d. LOCATION (City, town, or county) McMinnville, Oregon (State)

DATE REC'D BY LOCAL REG. July 28 1969
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 30 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3302
Local Reg. No. 1231
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH 270
a. COUNTY Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 357

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 200 4th. Ave. East

3. NAME OF DECEASED (Type or Print)
a. (First) HAZEL
b. (Middle) CHRISTINE
c. (Last) PRATT

4. DATE OF DEATH (Month) (Day) (Year) July 25, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 23, 1889
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Gunnison, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Christian Sanders — BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Martina Nielsen — BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 519 18 7170A
17. INFORMANT'S OWN SIGNATURE Sandra DeLucia — ADDRESS Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rt cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 5 dis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) age & arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19 57, to 25 Jul, 19 69, that I last saw the deceased alive on 24 Jul, 19 69, and that death occurred at 1:45A m., from the causes and on the date stated above.*

23a. SIGNATURE L. M. Scheber, Cec 4 583 (Degree or title)
23b. ADDRESS Jerome
23c. DATE SIGNED 26 Jul 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 29, 1969
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. July 28, 1969
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 24 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended August 19, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3303
Local Reg. No. 1232
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 357

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell 83355
d. STREET ADDRESS (If rural, give location): Box 306

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Stenna	Bertha	Stacy	July	26,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	Dec 2, 1887	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Wausau, Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Whittiker	England	Julia Durn	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	------ 0	526-44-6636 D	Helen Ultican	Hagerman, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-7-65, 19__, *to* 7-26, 19 69, *that I last saw the deceased alive on* 7-26-, 1969, *and that death occurred at* 11:35P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
457 Maurice E. Scheel, M.D.	Wendell, Idaho 83355	7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-30-69	Hagerman Cemetery	Hagerman, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 30, 1969	Louella M. Scherer	Eddie G. Leach	E 511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss.
County of ..... }

AUG 1 8 1969

Bureau of Vital Statistics

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain items on the certificate of death (Birth or Death) for Stenna Bertha Stacy (Name on Original Certificate) who died (Was Born or Died) on July 26, 1969 (Date of Event) in Jerome, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	Dec. 2, 1888	Dec. 2, 1887
Age	80	81

Subscribed and sworn to before me this 15th day of August, 1969

Helen H. Bycke

Notary Public, residing at Gooding, Idaho

My commission expires 2/16/72

(Seal)

Signed .....
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.) Funeral Director

137 Main St. - Gooding, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Gooding }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 15th day of August, 1969

Helen H. Bycke

Notary Public, residing at Gooding, Idaho

My commission expires 2/16/72

(Seal)

Signed Lena M. Teeter
(Signature of Any Credible Person)

134 3rd Ave E Gooding, Idaho
(Street Address, City, State)

FORM DH 60-155

Cert. No. 19610

8-14-69

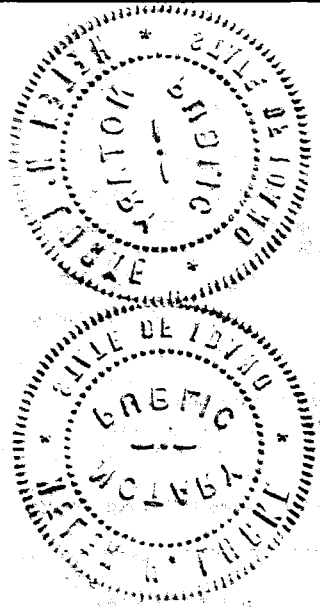

Certificate of Death
STATE OF IDAHO

State File No. _____
Local Reg. No. 1232
Reg. Dist. No. 440

BIRTH NO. RECEIVED

1. PLACE OF DEATH
a. COUNTY Jerome AUG 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
c. LENGTH OF STAY (In this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell 83355
d. STREET ADDRESS (If rural, give location) Box 306

3. NAME OF DECEASED (Type or Print) a. (First) Stenna b. (Middle) Bertha c. (Last) Stacy

4. DATE OF DEATH (Month) (Day) (Year) July 26, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Dec. 2, 1888
9. AGE (In years last birthday) 80 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Wausau, Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Whittiker BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Julia Durn BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -----
16. SOCIAL SECURITY NO. 526-44-6636D
17. INFORMANT'S OWN SIGNATURE Helen Ultican ADDRESS Hagerman, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) pneumonia

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) anterio-sclerotic heart disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-7-65, 19__, *to* 7-27-, 19 69, *that I last saw the deceased alive on* 7-27-, 19 69, *and that death occurred at* 11:35p *from the causes and on the date stated above.*

23a. SIGNATURE Maurice E. Scheel MD (Degree or title)
23b. ADDRESS Wendell, Idaho 83355
23c. DATE SIGNED 7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-30-1969
24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery
24d. LOCATION (City, town, or county) Hagerman, (State) Idaho

DATE REC'D BY LOCAL REG. July 30, 1969
REGISTRAR'S SIGNATURE Louella M. Deberer
26. EMBALMER Addie H. Fach
LICENSE NO. E-511

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 19 1969 AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

Dr Lanham

Certificate of Death
STATE OF IDAHO

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

State File No. 3304
Local Reg. No. 184
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene; LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor 261	d. STREET ADDRESS (If rural, give location) 1502 N. 5th St.

3. NAME OF DECEASED (Type or Print) a. (First) Gertrude	b. (Middle) M.	c. (Last) Biggins	4. DATE OF DEATH (Month) July (Day) 1, (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH April 25, 1877	9. AGE (In years last birthday) 92; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Mich.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Available	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Not Available	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) none 0	16. SOCIAL SECURITY NO. 518-03-0381	17. INFORMANT'S OWN SIGNATURE Norma Biggins	ADDRESS Idaho Coeur d'Alene	

2509

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) old age

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes mellitus

DUE TO (c) ASHD.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* nursing home *, 19____, that I last saw the deceased alive on* 6-1-69 *19____, and that death occurred at* 1350 *m., from the causes and on the date stated above.*

23a. SIGNATURE 622 Wm M. Lanham (Degree or title) MDI	23b. ADDRESS Hayden Lake, Idaho	23c. DATE SIGNED 7-3-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7-5-1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG. July 8, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3305
Local Reg. No. 191
Reg. Dist. No. 120

RECEIVED JUL 18 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 280 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hauser Lake
c. LENGTH OF STAY (In this place) 500 Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 Northern Pacific RR Depot

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 48 b. COUNTY Spokane 255
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Route 2 Box 276
d. STREET ADDRESS (If rural, give location) Rt. 2 Box 276

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	P.	Hansel	July 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Aug. 6, 1916	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Brakeman 10	Railroad	North Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John O. Hansel	UNKNOWN	Iva Patterson	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes 1	WW II 4	536-07-5819	Edna Hansel	Rt. 2 Box 276 Spo. Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8020

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) accidental traumatism by — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Railroad accident.
DUE TO (c) multiple crush injuries.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
1 accident	Hauser Lake 13	Hauser Lake 13 Kootenai 280 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Car derailed and crushed him.

22. I hereby certify that I attended the deceased from Did not , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. Coroner 583 4	Coeur d'alene Idaho	9-9-'69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7/3/69	Thornhill Valley F.H.	Oppertunity, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 11, 1969	Lorraine K. Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3306
Local Reg. No. 193
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho 13 b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene; c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location) 526 Reid Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) Eleanor	b. (Middle) M.	c. (Last) Lewis	4. DATE OF DEATH (Month) July (Day) 3, (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH Feb. 23, 1887	9. AGE (In years last birthday) 82	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Bristol, England	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry Feakes	BIRTHPLACE England	14. MOTHER'S MAIDEN NAME Mary Ann Unobtainable	BIRTHPLACE England		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) no 0	16. SOCIAL SECURITY NO. 518-68-7855	17. INFORMANT'S OWN SIGNATURE (Bo) Walter Lewis	ADDRESS Coeur d'Alene, Id		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5699

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Gastro intestinal hemorrhage	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. ~~DUE TO~~ (b)	unknown	4 Hours
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Abdominal aortic aneurism	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* April, 1969, *to* July 3, 1969, *that I last saw the deceased alive on* July 2, 1969, *and that death occurred at* 6 a m., *from the causes and on the date stated above.*

23a. SIGNATURE Wm Gummecht 192 (Degree or title) MD	23b. ADDRESS 302 a 5th	23c. DATE SIGNED 8 July 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 7, 1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho
DATE REC'D BY LOCAL REG. July 11, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel Coeur d'Alene Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

State File No. 3307
Local Reg. No. 186
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene; c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location) 5th & Locust

3. NAME OF DECEASED (Type or Print)	a. (First) Lewis	b. (Middle) Albert	c. (Last) Stensland	4. DATE OF DEATH (Month) (Day) (Year) July 3, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH Oct 24, 1885	9. AGE (In years last birthday) 83 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) North Dakota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Halvor Stensland	BIRTHPLACE Norway	14. MOTHER'S MAIDEN NAME Siri Loyte	BIRTHPLACE Norway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) None 0	16. SOCIAL SECURITY NO. 502-12-1847	17. INFORMANT'S OWN SIGNATURE X Helmer Stensland	ADDRESS Idaho Sandpoint	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Myocardial Infarction	30 min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 3, 1969, *to* July 3, 1969, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 530 C E Thompson (Degree or title) MD 1	23b. ADDRESS Coeur d'Alene Idaho	23c. DATE SIGNED July 7, 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7-9-1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG. July 10, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended Aug. 14, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3308
Local Reg. No. 199
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 0
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Garwood
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hi.95 - ¼ mile S. of Garwood 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 48 b. COUNTY Spokane 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 127 West Fifth Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Betty	Joe	Wingfield	July	3,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Cau.	Divorced 4	3-17-1931	38		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Ark.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
T. J. Wingfield	Ark.	Gladys Nutt	Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	531-38-5510	Kootenai County Police Cd'A, Idaho	

8147

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Accidental traumatism due to — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile Accident
DUE TO (c) Crushed Skull

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
1 Accident	Highway 06	¼ mile S. of Garwood 13	Kootenai 28 0	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Hit by car and ran over by truck

22. *I hereby certify that I attended the deceased from* did not *, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 William T. Wood, M.D., Coroner 4	Coeur d'Alene, Idaho	7-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7-3-69	Ball and Dodd F. H.	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 11,1969	Lorraine K. Brush	Fred Noland	E 493

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
AUG 12 1969
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Betty Joe Wingfield (Name on Original Certificate) Bureau of Vital Statistics who died (Was Born or Died) on July 3, 1969 (Date of Event)
in Kootenai County, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#8 & #9 Date of Birth & Age	3-17-69 - 39	March 17, 1931 - 38
#10a, 10b Usual Occupation	Unknown	Housewife; Own Home
#16 Social Security Number	Unknown	531-38-5510

Subscribed and sworn to before me this 6 day of Aug., 19 69

Notary Public, residing at Spokane Wn

My commission expires Oct. 13 69

(Seal)

Signed Edward T. Wallis
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

East 6809 - 9th - Spokane Wn
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Washington } ss.
County of Spokane }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 6 day of Aug., 19 69

Notary Public, residing at Spokane Wn

My commission expires Oct. 13 69

(Seal)

Signed Donald L. Ball
(Signature of Any Credible Person)

A-421 Division, Spokane Wn
(Street Address, City, State)

FORM DH 60-155

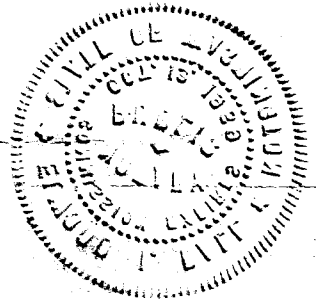

Certificate of Death
STATE OF IDAHO

State File No. _____
Local Reg. No. 199
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 18 1969

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Garwood
c. LENGTH OF STAY (In this place): Sec.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hi. 95-¼ mile S. of Garwood

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Washington
b. COUNTY: Spokane
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): 127 West Fifth Street

3. NAME OF DECEASED (Type or Print): a. (First) Betty; b. (Middle) Joe; c. (Last) Wingfield

4. DATE OF DEATH (Month) (Day) (Year): July 3, 1969

5. SEX: Female

6. COLOR OR RACE: Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: 3/17/69

9. AGE (In years last birthday): 39
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY: UNKNOWN

11. BIRTHPLACE (State or foreign country): Ark.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: T. J. Wingfield
BIRTHPLACE: Ark.

14. MOTHER'S MAIDEN NAME: Gladys Nutt
BIRTHPLACE: Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: Kootenai County Police Cd'A, Idaho
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): accidental traumatisim due to
INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): automobile accident
DUE TO (c): Crushed Skull.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Highway.

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): ¼ mile S of Garwood. Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Hit by car and run over by Truck.

22. *I hereby certify that I attended the deceased from* Did not _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood, M.D. Coroner

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 7-9-'69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 7/3/69

24c. NAME OF CEMETERY OR CREMATORY: Ball and Dodd F.H.

24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: July 11, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland

LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. Hughes

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3309
Local Reg. No. 183
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 JUL 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 48 COUNTY Spokane 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 634 E. 23rd Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	Edward	Bates	July 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	June 26, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stationary Engineer 21	Sacajawea Jr.Hi.	Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Bates	Colorado	Lulu Nutting	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
2	558-05-1492	Mrs. Mabel Bates	Spokane, Wash

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Probable — on basis of history
DUE TO (c) and findings

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-4 19 69 to 7-4 19 69 only 20 minutes, that I last saw the deceased alive on 7-4 19 69, and that death occurred at 2 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
251 M Hughes MD	Coeur d'Alene, Idaho	7-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-8-1969	Greenwood Memorial	Spokane Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 8, 1969	Lorraine K. Brueck	Cy Geraghty (BD)	

FIRM NAME: Thornhill-Geraghty, Spokane, Wn.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 2 1969
JUL 1 5 1969
JUL 1 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3310
Local Reg. No. 194
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 8 1969

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 4 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 404 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Unknown 261
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) Idaho State Univeresity

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) P. c. (Last) Mc Grane
4. DATE OF DEATH (Month) July (Day) 4, (Year) 1969
5. SEX Male
6. COLOR OR RACE Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH 3/10/44
9. AGE (In years last birthday) 25 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY I.S.U. Student
11. BIRTHPLACE (State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joe Mc Grane BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Leone Wood BIRTHPLACE Utah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1 (If yes, give war or dates of service) Veit Nam 7
16. SOCIAL SECURITY NO. 518-46-3408
17. INFORMANT'S OWN SIGNATURE Joe Mc Grane ADDRESS Idaho Falls, Idaho

8/69

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) accidental traumatism due to — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) automobile accident.
DUE TO (c) Crushed aorta. — Several hours

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) accident 1
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) Fernan Village 13 (COUNTY) Kootenai 28 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Car struck a tree.

22. I hereby certify that I attended the deceased from Did not, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE William T. Wood, M.D. (Degree or title) Coroner 4 583
23b. ADDRESS Coeur d'alene Idaho
23c. DATE SIGNED 7-9-'69
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/6/69
24c. NAME OF CEMETERY OR CREMATORY Buck Funeral Home
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho
DATE REC'D BY LOCAL REG. July 11, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred Noland
LICENSE NO. E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 18 1969
JUL 25 1969
AUG 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

State File No. 3311
Local Reg. No. 187
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Kootenai (281) — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene — LENGTH OF STAY (In this place): 1 day (301)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital (101)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE: Idaho — b. COUNTY: Kootenai — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene (281) — d. STREET ADDRESS (If rural, give location): 831 N. 7th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Laura	Elsie	Swenson	July 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced (4)	Dec. 20, 1920	48		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Own Home	Harrison, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles D. Brown	Idaho	Elsie May Ward	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No (2)	None (0)	519-12-8747	X Carl C. Swenson	Idaho Coeur d'Al

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c) — (2509)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute myocardial infarction	7 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Diabetes mellitus	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-4, 1969, *to* 7-5, 1969, *that I last saw the deceased alive on* 7-5, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
658R. H. Englestein MD	Hayden Lake, Idaho	7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-9-1969	Forest Cemetery	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Lorraine K. Brush	Bill Duff	E-439

FIRM NAME: English Chapel Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 9 1969
FEB 6 1970 MAY 2 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3312
Local Reg. No. 195
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 18 1969 Vital Statistics Bureau of Health

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) Days 300
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 191

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 821 Mullen Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLIFFORD	WESTON	PARKS	July 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Married 3	3/15/1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Misc.	Ill.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Orsamous Parks	Ill.	Eudora E. Porter	Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
2	0	539-10-9847A	Laura Parks	821 Emma Ave. CdA, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* July 6, 19 69, *that I last saw the deceased alive on* July 6, 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C E Thompson 530	MD	920 Ironwood Dr. Coeur d Alene, Idaho	July 10, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 8, 1969	Restlawn	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 11, 1969	Lorraine K. Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 1 3 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3313
Local Reg. No. 202
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 28 1969

1. PLACE OF DEATH
a. COUNTY 280 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene Bur
c. LENGTH OF STAY (In this place) 300 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ozzie's Resort Cd'A Lake 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) 1301 St. Maries Ave.

3. NAME OF DECEASED (Type or Print) a. (First) MARK b. (Middle) HARRISON c. (Last) RAMSEY

4. DATE OF DEATH (Month) July (Day) 7, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 8/8/53

9. AGE (In years last birthday): 15
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Calley James Ramsey BIRTHPLACE: Penn.

14. MOTHER'S MAIDEN NAME: Hazel Kile BIRTHPLACE: South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 2 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE ADDRESS 1301 St. Maries Ave.
Calley Ramsey Coeur d' Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Lake Coeur d'alene

21c. (CITY, TOWN, OR TOWNSHIP) Coeur d'alene 13 (COUNTY) 280 Kootenai (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Fell off float & drowned.

22. I hereby certify that I attended the deceased from Did not - , 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William T. Wood, M.D. Coroner 583 4

23b. ADDRESS Coeur d'alene, Idaho

23c. DATE SIGNED 7-19-'69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/19/69

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. July 24, 1969

REGISTRAR'S SIGNATURE Wm. T. Wood

25. EMBALMER Fred Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3314
Local Reg. No. 196
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 18 1969

1. PLACE OF DEATH
a. COUNTY 28/Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 53 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 411 N. 18th. Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) 411 N. 18th, Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CLAUDE	H.	RAWSON	July 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Married 3	1/1/09	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mill Worker 17	Lumber	Minnesota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roy Rawson	UNKNOWN	Emma Grove	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 4	518-03-9857	Leona Rawson	411 N. 18th Cd'A, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 50, *to* ____, 19 69, *that I last saw the deceased alive on* ____, 19 68, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William P. Wood, M.D. Coroner 4	Coeur d'alene Idaho	7-9-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/11/69	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 11, 1969	Lorraine K. Brush	Fred Noland	E-493

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 1969

AUG 13 1969

JAN 28 1985

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3315
Local Reg. No. 197
Reg. Dist. No. 120

RECEIVED JUL 18 1969

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: KOOTENAI 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): COEUR d'ALENE
c. LENGTH OF STAY (in this place): 4 YEARS 104
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): COEUR d'ALENE HOMES 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: KOOTENAI 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): COEUR d'ALENE
d. STREET ADDRESS (If rural, give location): 706 COEURd'ALENE AVENUE

3. NAME OF DECEASED (Type or Print)
a. (First): EMIL
b. (Middle): MARTIN
c. (Last): REISENAUER

4. DATE OF DEATH (Month) (Day) (Year): JULY 7, 1969

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: OCTOBER 25, 1886
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER 04
10b. KIND OF BUSINESS OR INDUSTRY: GRAIN FARM
11. BIRTHPLACE (State or foreign country): FT. SCOTT, KANSAS
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CONRAD REISENAUER — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: ELIZABETH TRAPP — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES 1 — (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 538-36-4359
17. INFORMANT'S OWN SIGNATURE: X Lucy R Reisenauer — ADDRESS: COEUR d'ALENE, ID.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Myocarditio-chronic	2 months
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arthrioscleratic cardiovascular disease--severe	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	cerebral vascular accident Pyelomyshitis--recurrent	3 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 10, 1967, *to* July 7, 1969, *that I last saw the deceased alive on* July 7, 1969, *and that death occurred at* 1:30P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): X H. Don Moseley, M.D. 375 — H. Don Moseley MD
23b. ADDRESS: 421 Cd'A Aven. Coeur d'Alene
23c. DATE SIGNED: July 9, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: JULY 10, 1969
24c. NAME OF CEMETERY OR CREMATORY: COLTON CATHOLIC CEMETERY
24d. LOCATION (City, town, or county) (State): COLTON, WASHINGTON

DATE REC'D BY LOCAL REG.: July 17, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Howard O. Kimball
LICENSE NO.: QL 801

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: KIMBALL FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 18 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 18 1969 Bureau of Vital Statistics

State File No. 3316
Local Reg. No. 190
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 126

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) 111S. 6th. St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MYRL	A.	FELCH	July 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	Cau.	Married 3	12/12/96	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Road Work 11	Ida. State Highway	Vermont	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Felch	U.S.A.	Bertha Smith	U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	519-10-4223	Agness Felch	111S. 6th. Cd'A, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4419

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ruptured Aortic Aneurysm.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocardial Infarction age undetermined

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-6-66 , 19____ , *to* present , 19____ , *that I last saw the deceased alive on* 7-8-69 , 19____ , *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
128 [signature] M.D.	920 Ironwood Dr. Coeur d'Alene	7-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/10/69	Bonners Ferry	Bonners Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 11, 1969	Lorraine K. Brush	Frank Houde	E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969

OCT 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 0 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 14 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3317
Local Reg. No. 217
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 6 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene c. LENGTH OF STAY (In this place) 800	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene 281
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location) 1844 Melrose

3. NAME OF DECEASED (Type or Print) a. (First) Michael Patrick b. (Middle) O'Brien c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 8, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 3, 1967	9. AGE (In years last birthday) 2 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Coeur d'Alene, Ida	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward O'Brien BIRTHPLACE Pennsylvania		14. MOTHER'S MAIDEN NAME Barbara C. Jacobson BIRTHPLACE Idaho		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) None 0	16. SOCIAL SECURITY NO. None	17. INFORMANT'S OWN SIGNATURE Edward L O'Brien ADDRESS Idaho Coeur d'Alene		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

462 X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac arrest	minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute Klebsiella pharyngitis	2 days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Epilepsy	

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1968, *to* July 7, 1969, *that I last saw the deceased alive on* July 8 1969, *and that death occurred at* 11:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Wilbur H. Tyler 313 (Degree or title) M.D. Pt. 1	23b. ADDRESS 411 Coeur d'Alene Ave., CH, Idaho	23c. DATE SIGNED 7.24.69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7-10-1969	24c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery	24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho
DATE REC'D BY LOCAL REG. July 25, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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D-67-2637

Certificate of Death

STATE OF IDAHO

State File No. 3318
Local Reg. No. 200
Reg. Dist. No. 120

RECEIVED JUL 18 1969

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Coeur d' Alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print): a. (First) ALBERT b. (Middle) C. c. (Last) WUNDERLICH

4. DATE OF DEATH (Month) (Day) (Year): July 8, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 9-10-1877

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 91

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Owner 29 operator

10b. KIND OF BUSINESS OR INDUSTRY: Pole Co.

11. BIRTHPLACE (State or foreign country): Appleton (Rural), Wisconsin

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Wunderlich — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Augusta Not obt — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 0 4369

16. SOCIAL SECURITY NO.: 518-01-6335 A

17. INFORMANT'S OWN SIGNATURE: Jack A. Wunderlich — ADDRESS: Wn. E. 15406 Broadway-Veradale

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) Arteriosclerosis — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1965, *to* _____, 1969, *that I last saw the deceased alive on* 3-15, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood, M.D. — **23b. ADDRESS**: Coeur d' alene Idaho — **23c. DATE SIGNED**: 7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3 — **24b. DATE**: 7-9-1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Cremation-Smith Funeral Home — **24d. LOCATION** (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: July 17, 1969 — REGISTRAR'S SIGNATURE: Lorraine K Bruesh

25. EMBALMER: Frank Houde — LICENSE NO.: E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3319
Local Reg. No. 192
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 281 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 101 Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 280 Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Route I

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Roy	John	Jessick	July 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Jan. 16, 1916	53		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boat Operator 06	N.W. Timber	Coeur d' Alene, Ida	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Jessick	Austria	Anna Bozona	Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W. W. II	518-03-0476	Mrs. Roy Jessick	Idaho Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

201X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-3, 1969, to 7-9, 1969, that I last saw the deceased alive on 7-9, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 512	Coeur d'alene, Idaho	7-11-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-12-1969	St. Thomas Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 16, 1969	Lorraine K Brush	Bill Cuff	E-439

FIRM NAME: English Chapel-Coeur d' Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969

JUL 2 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 2 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3320
Local Reg. No. 289
Reg. Dist. No. 120

RECEIVED JUL 28 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 281 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place) 315 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 707 Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Samuels
d. STREET ADDRESS (If rural, give location) Route 1, Box 219

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Phillip	Robert	Lewis	July 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	July 18, 1904	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck driver-mechanic 27	Transportation	Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
No record	no record	Minerva Bennett	Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 3	353 05 4199 A	Mrs. Harriet E. Lewis	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Abdominal Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4412

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 22, 1969, *to* July 9, 1969, *that I last saw the deceased alive on* July 9, 1969, *and that death occurred at* 4 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Thompson MD 530	920 Ironwood Dr. Ve Coeur d Alene Idaho	July 12, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	July 9, 1969	Pinecrest Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 23, 1969	Wendell J. Broughton	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 28 1969

MAR 03 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized for release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 18 1969 Bureau of Vital Statistics

State File No. 3321
Local Reg. No. 198
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 280 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hayden Lake
c. LENGTH OF STAY (In this place) Sec. 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) On Lakeview Dr. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 48
b. COUNTY Spokane 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 1115 E. 26th. St.

3. NAME OF DECEASED (Type or Print)
a. (First) ELIZABETH
b. (Middle) L.
c. (Last) SOUTHER

4. DATE OF DEATH (Month) (Day) (Year) July 13, 1969

5. SEX Female
6. COLOR OR RACE Caul
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 21, 1917
9. AGE (In years last birthday) 51
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Raymond C. Falch
BIRTHPLACE UNKNOWN
14. MOTHER'S MAIDEN NAME Marie Fey
BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. ✓
17. INFORMANT'S OWN SIGNATURE Gordon Souther
ADDRESS 1115 E. 26th. St. Spokane, Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 13, 1969, to July 13, 1969, that I last saw the deceased alive pronounced dead, and that death occurred at 8 P m., from the causes and on the date stated above.

23a. SIGNATURE 796 [signature] (Degree or title) MD 01
23b. ADDRESS Cedar & Dane
23c. DATE SIGNED 7/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/14/69
24c. NAME OF CEMETERY OR CREMATORY Thornhill-Gearty F.H.
24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. July 17, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Frank Houde
LICENSE NO. E-521

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 2 1969

JUN 1 4 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 3 0 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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DK FOX

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 28 1969 Bureau of Vital Statistics

State File No. 3322
Local Reg. No. 203
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1310 Front 000	d. STREET ADDRESS (If rural, give location) 1310 Front

3. NAME OF DECEASED (Type or Print) a. (First) Mary	b. (Middle) Angela	c. (Last) Tooley	4. DATE OF DEATH (Month) July (Day) 14, (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH July 1, 1879	9. AGE (In years last birthday) 90 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Minn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen Sengar	BIRTHPLACE France	14. MOTHER'S MAIDEN NAME (Unobtainable)	BIRTHPLACE (Unobtainable Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2	(If yes, give war or dates of service) no 0	16. SOCIAL SECURITY NO. 518-05-3629D	17. INFORMANT'S OWN SIGNATURE X Florence M. Baillie	ADDRESS Coeur d'Alene

18. CAUSE OF DEATH 2509
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	cerebral-vascular accident.	1 hour.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	diabetes mellitus and	
DUE TO (c)	generalized and cerebral arterio-sclerosis.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	-	

19a. DATE OF OPERATION -	19b. MAJOR FINDINGS OF OPERATION -	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify) -	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) -
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) - m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? -

22. *I hereby certify that I attended the deceased from* 1953, *to* July 14, 1969, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 174 (Degree or title) M.D.	23b. ADDRESS 212 S. 11th, Coeur d' Alene	23c. DATE SIGNED 7-16-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7-17-1969	24c. NAME OF CEMETERY OR CREMATORY St Thomas Cemetery
24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho		
DATE REC'D BY LOCAL REG. July 18, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Riplinger, Jr.
LICENSE NO. #397		

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3323
Local Reg. No. 218
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY Kootenai 28 — AUG 6 1969 — 500
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene — LENGTH OF STAY (In this place) Sec.
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital 10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE Washington 48 — COUNTY Spokane 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 10600 8th. Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PAMELA		PARNELL	July 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	/ Never Married	3/25/56	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	School	Nevada	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edwin L. Parnell	Okla.	Marlene Amell	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	NONE	ed Parnell	10600 8th. st. Spokane Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) accidental traumatism due to — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) automobile accident — Sudden.
DUE TO (c) Crushed Skull. — "

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg. etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident 1	Highway 06	near Huetter 13 Kootenai 280 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
7-16-'69 m.		Car rolled over & threw her out.

22. *I hereby certify that I attended the deceased from* Did not *, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood M.D. 583 Coroner 4	Coeur d'Alene Idaho	7-24-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	7/21/69	Forest Cemetery	Coeur d' lene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 17, 1969	Lorraine K. Brush	Frank Houde	E-521

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

AUG 9 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3324
Local Reg. No. 213
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 6 1969 Bureau of Vital Statistics

281

1. PLACE OF DEATH
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alen
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) 821 Hastings Avenue

3. NAME OF DECEASED (Type or Print) a. (First) ELSIE b. (Middle) c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year) July 17, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 4/15/24

9. AGE (In years last birthday) 45
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-school teac 12

10b. KIND OF BUSINESS OR INDUSTRY Home-School

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ned Bush
BIRTHPLACE Austria

14. MOTHER'S MAIDEN NAME UNKNOWN
BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) 2 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Le Roy Johnson
ADDRESS 821 Hastings Cd8AIda

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1929

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Intra cranial Costicaytoma — INTERVAL BETWEEN ONSET AND DEATH 18 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November, 1968 to July 17, 1969, that I last saw the deceased alive on July 17, 1969, and that death occurred at 8 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 193 MD

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/21/69

24c. NAME OF CEMETERY OR CREMATORY RestlawnMem. Park

24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. July 23, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Frank Houde

LICENSE NO. E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 06 1998

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3325
Local Reg. No. 204
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 6 1969 Bureau of Vital Statistics

281 201 101 280

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 1month
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Medimont
d. STREET ADDRESS (If rural, give location): P.O. Box 28

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jessie	B.	Arrasmith	July 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	March 19,1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	California	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry H. Noble	Indiana	Emma Frances Groves	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	none 0	518-38-7889A	Lillie Burmeister	Medimont

4124

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Edema

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive heart failure
DUE TO (c) Arteriosclerotic cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus with acidosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-13-69, 19___, *to* 7-22-69, 19___, *that I last saw the deceased alive on* 6-22-69, 19___, *and that death occurred at* 11 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
087 C. J. Culbertson M.D.	Hayden Lake, Idaho 83835	7-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 22, 1969	Medimont Cemetery	Medimont Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1, 1969	Lorraine L. Brush	Bill Cluff	E 439

FIRM NAME: English Chapel Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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wood

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3326
Local Reg. No. 212
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Kootenai 281 — AUG 6 1969 — b. CITY OR TOWN: Coeur d' Alene — c. LENGTH OF STAY (in this place): 000 — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace 340

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — a. STATE: Washington 48 — COUNTY: Spokane 555 — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane — d. STREET ADDRESS (If rural, give location): 3227 W. 8th. Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ANTON	(NMN)	JOHNSON	July 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	4-18-1879	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Machinist 29	Milw. R.R.	Sweden	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hokan Johnson	Sweden	Hannah Nelson	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2 0	707-14-9228	Hulda Johnson	3227 W. 8th.-Spokane, Wn.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) arteriosclerosis — Yeas.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19 68, *to* 7-18, 19 69, *that I last saw the deceased alive on* 7-18, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William F. Wood, M.D.	Coeur d' alene Idaho	9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-28-1969	Greenwood Memorial Terrace	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 25, 1969	Lorraine K. Brush	Michael Webb	985

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Funeral Home, Spokane, Wn

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3327
Local Reg. No. 220
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 281 Kootenai AUG 6 1969 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION 509 Garden Avenue 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Nezperce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 351
d. STREET ADDRESS (If rural, give location) 516 5th. Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PHILIP		SCHOOLER	July 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Widowed 2	1/14/88	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Wheat Farm		U. S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin H. Schooler	U.S.A.	Martha Turk	U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or ... of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	538-34-9555	H oward Schooler	502 Garden CdA. Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable acute Coronary occlusion. — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Several years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did not. , 19____, to _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Lund M.D. Coroner 583 4	Coeur d'alene Idaho	7-29-'69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/23/69	Genesee Cemetery	Genesse, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 30, 1969	Lorraine K. Brush	Fred Noland	E- 493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 1969

DEC 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 6 1969 Bureau of Vital Statistics

State File No. 3328
Local Reg. No. 208
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeurd' Alene c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeurd' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1223 Gov't Way 000	d. STREET ADDRESS (If rural, give location) 1223 Gov't Way

3. NAME OF DECEASED (Type or Print) a. (First) Elvira	b. (Middle) Evans	c. (Last) Cummings	4. DATE OF DEATH (Month) July (Day) 19, (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4	8. DATE OF BIRTH Feb. 20, 1880	9. AGE (In years last birthday) 89 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Wales	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Evans	BIRTHPLACE Wales	14. MOTHER'S MAIDEN NAME Martha Lydia Laugher	BIRTHPLACE Wales	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -------2 (If yes, give war or dates of service) ------0	16. SOCIAL SECURITY NO. 518-54-4157	17. INFORMANT'S OWN SIGNATURE Warren Evans	ADDRESS Coeur d'Alene Ida	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4349

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH 1 day.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 22, 1962, *to* July 19, 1969, *that I last saw the deceased alive on* Feb. 8, 1966, *and that death occurred at* 8:00 a.m. *m., from the causes and on the date stated above.*

23a. SIGNATURE 225 Rex Henson (Degree or title) M.D. 1	23b. ADDRESS Coeur d'Alene Idaho	23c. DATE SIGNED July 23, 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7-22-1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho
DATE REC'D BY LOCAL REG. Aug. 1, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 11 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
RECEIVED STATE OF IDAHO

State File No. 3329
Local Reg. No. 205
Reg. Dist. No. 120

BIRTH NO.

AUG 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Kootenai 280	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls c. LENGTH OF STAY (In this place): 15 Years 115	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls 280
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 213 Seventh Street 000	d. STREET ADDRESS (If rural, give location): 213 Seventh Street

3. NAME OF DECEASED (Type or Print) a. (First): HILMA	b. (Middle): M.	c. (Last): BELL	4. DATE OF DEATH (Month) (Day) (Year): July 22, 1969	
5. SEX: Female	6. COLOR OR RACE: Cau.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: 12/18/04	9. AGE (In years last birthday): 64 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Andover, South Dakota	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Andrew Rinke	BIRTHPLACE: Russia	14. MOTHER'S MAIDEN NAME: Katherine Henderickson	BIRTHPLACE: Finland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 0	16. SOCIAL SECURITY NO.: 519-12-8175	17. INFORMANT'S OWN SIGNATURE: Lester Bell	ADDRESS: 213 7th. St. Post Falls, Idaho	

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood, M.D. (Degree or title): Coroner 4 583	23b. ADDRESS: Coeur d'alene Idaho	23c. DATE SIGNED: 7-30-'69.	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 7/26/69	24c. NAME OF CEMETERY OR CREMATORY: Straub's Funeral Home	24d. LOCATION (City, town, or county) (State): Eureka, South Dakota
DATE REC'D BY LOCAL REG.: July 31, 1969	REGISTRAR'S SIGNATURE: Lorraine K. Brush	25. EMBALMER: Frank Houde	LICENSE NO.: E-521

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 8 1969

MAR 30 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3330
Local Reg. No. 214
Reg. Dist. No. 120

BIRTH NO. 69-3892

RECEIVED AUG 6 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Kootenai 280	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Route #3 c. LENGTH OF STAY (In this place): 3 Months 203	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Route #3 280
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. #3 Box 561 Cd'A, Ida 000	d. STREET ADDRESS (If rural, give location): Route #3 Box 561

3. NAME OF DECEASED (Type or Print)	a. (First): ROBERT	b. (Middle): WENDELL	c. (Last): KLEINSMITH	4. DATE OF DEATH (Month) (Day) (Year): July 22, 1969	
5. SEX: Male	6. COLOR OR RACE: Cau.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: 4/11/69	9. AGE (In years last birthday): IF UNDER 1 YR. Months 3 Days 11	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE 02	10b. KIND OF BUSINESS OR INDUSTRY: NONE	11. BIRTHPLACE (State or foreign country): Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Gary Kleinsmith	BIRTHPLACE: Lewiston, Ida.	14. MOTHER'S MAIDEN NAME: Kristine Higbee	BIRTHPLACE: Montana		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 8	16. SOCIAL SECURITY NO.: None	17. INFORMANT'S OWN SIGNATURE: Gary Kleinsmith	ADDRESS: 907 Mill Avenue Coeur d8 Alene, Ida.		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

0389

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Sudden death - Cause ill defined. — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): ——

DUE TO (c): Probable Septicemia — INTERVAL BETWEEN ONSET AND DEATH: "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?		

22. *I hereby certify that I attended the deceased from ____, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William F. Dod, M.D. Coroner 4 583	23b. ADDRESS: Coeur d'alene Idaho	23c. DATE SIGNED: 7-24-'69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2	24b. DATE: 7/24/69	24c. NAME OF CEMETERY OR CREMATORY: Hazen and Jaeger	24d. LOCATION (City, town, or county) (State): Spokane, Washington
DATE REC'D BY LOCAL REG.: July 23 1969	REGISTRAR'S SIGNATURE: Lorraine K. Brush	25. EMBALMER: Fred Noland	LICENSE NO.: E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3331
Local Reg. No. 207
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 AUG 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Nursing Home 340

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) 922 River Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bertha		Crampton	July	24,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	white	2	10-10-1887	81	9	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Michigan	U.S.A.

13. FATHER'S NAME		BIRTHPLACE	14. MOTHER'S MAIDEN NAME		BIRTHPLACE
Unob.	Beckwith	Unob.	Unob.	Woolston	Unob.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
----2	----0----	518-60-4914	Mrs. Julie Harnell	Coeur d'Alene Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Accident

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonitis.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 1, 1968, 19____, *to* present, 19____, *that I last saw the deceased alive on* 7-24-69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	920 Ironwood Dr. Coeur d'Alene, Ida.	7-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 28, 1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 1, 1969	Lorraine K. Brush	Bill Neff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3332
Local Reg. No. 209
Reg. Dist. No. 120

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281 AUG 6 1969 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Terrace 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene, Idaho
d. STREET ADDRESS (If rural, give location) 201 1st St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Amy	Jane	Eggan	July 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	married 3	Dec. 8, 1884	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	own home	Wisc.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hiram Ward	Ill.	Teresa Cooper	Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	no 0	532-32-3034	A Charles Eggan	Idaho. Coeur d'Alene

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of cervix
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Vesicovaginal fistula
Colostomy, post proctectomy

180X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 3 Aug 1967, to 24 Jul 1969, that I last saw the deceased alive on 23 Jul 1969, and that death occurred at 7:45 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 786 M.D.	411 Coeur d'Alene Ave.	24 Jul 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 28 1969	Restlawn Memorial Park	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 1, 1969	Lorraine K. Brush	[signature]	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3333
Local Reg. No. 210
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 6 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai (281)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene (300)
c. LENGTH OF STAY (in this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital (101)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls (280)
d. STREET ADDRESS (If rural, give location): 710 Spokane Street

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): JOHNSON
c. (Last): HEDGE

4. DATE OF DEATH: (Month) July (Day) 25, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 4/13/79

9. AGE (In years last birthday): 90
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoemaker 21

10b. KIND OF BUSINESS OR INDUSTRY: Shoeshop

11. BIRTHPLACE (State or foreign country): Roanoke, Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David Crockett Hedge
BIRTHPLACE: Va.

14. MOTHER'S MAIDEN NAME: UNKNOWN
BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 501-07-7436

17. INFORMANT'S OWN SIGNATURE: Arthur Hedge
ADDRESS: Post Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma of the stomach (1519) — INTERVAL BETWEEN ONSET AND DEATH: 6-8 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 16, 1969

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of stomach

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 28, 1969 *to* July 25, 1969, *that I last saw the deceased alive on* July 25, 1969, *and that death occurred at* ____ P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 568 W. Wray Wilson MD

23b. ADDRESS: Coeur d'Alene, Ida

23c. DATE SIGNED: 7-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 7/26/69

24c. NAME OF CEMETERY OR CREMATORY: Price-Lisko F. H.

24d. LOCATION (City, town, or county) (State): Dickinson, North Dakota

DATE REC'D BY LOCAL REG.: July 30, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Frank Houde

LICENSE NO.: E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....:.....:.....

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Certificate of Death
STATE OF IDAHO

State File No. 3334
Local Reg. No. 211
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
AUG 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 7 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls, 280
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Minnie
b. (Middle) Pearl
c. (Last) Hodge

4. DATE OF DEATH (Month) July (Day) 25, (Year) 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Sept. 5, 1905
9. AGE (In years last birthday) 63 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jack Campbell — BIRTHPLACE N.C.
14. MOTHER'S MAIDEN NAME Martha Greer — BIRTHPLACE N.C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 — (If yes, give war or dates of service) none 0
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE X R C Hodge, Post Falls — ADDRESS 2da.

18. CAUSE OF DEATH 4100
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarct acute — INTERVAL BETWEEN ONSET AND DEATH: abrupt

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) coronary atherosclerosis c angina — long duration

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension — long duration

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 7-27, 19 69, *that I last saw the deceased alive on* June, 19 69, *and that death occurred at* AM *m., from the causes and on the date stated above.*

23a. SIGNATURE 251 M Hughes MD (Degree or title)
23b. ADDRESS Coeur d'Alene Idaho
23c. DATE SIGNED 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-28-1969
24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cem.
24d. LOCATION (City, town, or county) Post Falls, (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 1, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Duff
LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 8 1970

MAY 2 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
AUG 6 1969
Bureau of Vital Statistics

State File No. 3335
Local Reg. No. 206
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 314	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeurd' Alene 281
LENGTH OF STAY (In this place): 2 wk.	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location): Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print) a. (First): Lottie	b. (Middle):	c. (Last): Boots	4. DATE OF DEATH (Month) (Day) (Year): July 27, 1969		
5. SEX: Female	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2	8. DATE OF BIRTH: May 25, 1882	9. AGE (In years last birthday): 87	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Minn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Unobtainable	BIRTHPLACE	14. MOTHER'S MAIDEN NAME: Unobtainable	BIRTHPLACE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----- 2 (If yes, give war or dates of service) ----- 0 --	16. SOCIAL SECURITY NO.: 518-16-9602	17. INFORMANT'S OWN SIGNATURE: Curt Lundquist	ADDRESS: Coeur d'Alene Ida.		

4379

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AUG- 12, 1968, *to* July 27, 1969, *that I last saw the deceased alive on* July 27, 1969, *and that death occurred at* 12:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: G. E. Thompson 530 (Degree or title) MD	23b. ADDRESS: 920 Ironwood Dr Coeur d Alene Idaho	23c. DATE SIGNED: July 31, 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: 7-31-69	24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery	24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG.: Aug. 1, 1969	REGISTRAR'S SIGNATURE: Lorraine K. Brush	25. EMBALMER: N. F. Riplinger Jr.	LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3336
Local Reg. No. 226
Reg. Dist. No. 120

RECEIVED AUG 12 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 281 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 112 Lakeside

3. NAME OF DECEASED (Type or Print)
a. (First) Henry
b. (Middle) C.
c. (Last) Jolgen

4. DATE OF DEATH (Month) July (Day) 27, (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 5, 1893
9. AGE (In years last birthday) 75
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millworker-Miner 17
10b. KIND OF BUSINESS OR INDUSTRY Saw Mill-Mines
11. BIRTHPLACE (State or foreign country) Minn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hans Jolgen
BIRTHPLACE Unob.
14. MOTHER'S MAIDEN NAME Caroline Anderson
BIRTHPLACE Unob.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1
(If yes, give war or dates of service) W.W. I 3
16. SOCIAL SECURITY NO. 518-01-8754
17. INFORMANT'S OWN SIGNATURE (BR) Mrs. Rita Appelberg
ADDRESS Coeur d'Alene Ida

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable Coronary occlusion
INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. Coroner 583 (Degree or title) 4
23b. ADDRESS Coeur d'Alene Idaho
23c. DATE SIGNED 8-5-'69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 7-30-1969
24c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Pk.
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 6, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
26. EMBALMER [signature]
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3337
Local Reg. No. 215
Reg. Dist. No. 120

RECEIVED
AUG 6 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway #10 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): 718 8th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Helen
b. (Middle): G.
c. (Last): McCuaig

4. DATE OF DEATH (Month) (Day) (Year): July 27 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: FEb. 13, 1903
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: Public Schools
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James GAultnoy — BIRTHPLACE: Unobtainable
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): none 0
16. SOCIAL SECURITY NO.: 519-22-7772
17. INFORMANT'S OWN SIGNATURE: James D. McCuaig — ADDRESS: Kent, Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Head & Chest Injuries — INTERVAL BETWEEN ONSET AND DEATH: about 130

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway #1006
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Kootenai 280, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 27 1969 m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: One car accident near Port of Entry

22. *I hereby certify that I attended the deceased from* Feb 2, 1962, *to* July 27, 1969, *that I last saw the deceased alive on* July 27, 1969, *and that death occurred at* 5:50 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Chilbus H. Hyon Jr. M.D. 1 — 313
23b. ADDRESS: 411 Coeur d'Alene Ave, Coeur d'Alene
23c. DATE SIGNED: 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7-31-1969
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idah0

DATE REC'D BY LOCAL REG.: Aug. 1, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: M. K. Pfeiffer Jr. — LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 0 6 1991

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3338
Local Reg. No. 219
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 6 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location) 723 Military Drive

3. NAME OF DECEASED (Type or Print) a. (First) Johanna	b. (Middle) M.	c. (Last) Raugust	4. DATE OF DEATH (Month) July (Day) 27 (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH March 16, 1889	9. AGE (In years last birthday) 80 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) So. Russia	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unobtainable	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Unobtainable	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -----2 (If yes, give war or dates of service) ----0---	16. SOCIAL SECURITY NO. None	17. INFORMANT'S OWN SIGNATURE Ethel F. Raugust	ADDRESS 820 St. Maries Ave, Coeur d'Alene, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial infarct acute	abrupt
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	coronary Thero sclerosis & angina	long duration
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hypertension	long duration

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1969 *, to* 7-27 *, 19*69 *, that I last saw the deceased alive on* June *, 19*69 *, and that death occurred at* A *m., from the causes and on the date stated above.*

23a. SIGNATURE 251 [signature] (Degree or title) 1	23b. ADDRESS Coeur d'Alene Idaho	23c. DATE SIGNED 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE 7-30-1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. Aug 1, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER [signature]	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 6 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3339
Local Reg. No. 216
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN Coeur d' Alene
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Terrace 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 280
d. STREET ADDRESS (If rural, give location) Star Route

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Claudia	M.	Modine	July 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	March 5, 1883	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Dale	Germany	Ema Davis	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	none 0	518-38-7905A	Mrs. Myrl Myers	Coeur d'Alene

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca Head of Pancreas — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Gen arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 1969 to 7/28, 1969, that I last saw the deceased alive on 7/28, 1969, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Coeur d'Alene	7/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-1-1969	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 1, 1969	Lorraine K. Brush	[signature]	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAY 1 4 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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ADDITIONAL REMARKS by Physician.....

State File No. 3340
Local Reg. No. 224
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Coeur d' alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print)
a. (First): Julius
b. (Middle): (nmn)
c. (Last): Gilbertson

4. DATE OF DEATH (Month) (Day) (Year): July 30, 1969

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Sept. 17, 1871
9. AGE (In years last birthday): 97 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber Grader 17
10b. KIND OF BUSINESS OR INDUSTRY: Potlatch Forest
11. BIRTHPLACE (State or foreign country): Inc. Norway
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unobtainable — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): none 0
16. SOCIAL SECURITY NO.: 518-01-0473
17. INFORMANT'S OWN SIGNATURE: Mrs Pearl J. Prosser — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASHD.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: age

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1966 *to* 7-30, 1969 *that I last saw the deceased alive on* 7-30, 1969, *and that death occurred at* 6:20 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John McFanham MD
23b. ADDRESS: Hayden Lake, Idaho
23c. DATE SIGNED: 8-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-2-1969
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Ikaho

DATE REC'D BY LOCAL REG.: Aug 5 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N. F. Riplinger Jr.
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3341
Local Reg. No. 228
Reg. Dist. No. 120

RECEIVED AUG 12 1969 Bureau of

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): 2 Years 102
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene 281
d. STREET ADDRESS (If rural, give location): 2514 N. 7th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Alma
b. (Middle):
c. (Last): Ogin

4. DATE OF DEATH (Month) (Day) (Year): July 30, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 30, 1886
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Unobtainable
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): none 0
16. SOCIAL SECURITY NO.: 519-60-9907
17. INFORMANT'S OWN SIGNATURE — ADDRESS: J Records-Pinewood manor, Coeur d'Alene

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cerebral Arteriosclerosis — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1966, *to* July 30, 1969, *that I last saw the deceased alive on* July 30, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Thompson 530 MD1
23b. ADDRESS: 970 Ironwood Dr. Coeur d'Alene Idaho
23c. DATE SIGNED: August 6, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: Aug 8, 1969
REGISTRAR'S SIGNATURE: Lorraine K Brush
25. EMBALMER: Bill Huff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3342
Local Reg. No. 221
Reg. Dist. No. 12c

RECEIVED AUG 12 1969 Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) Pinewood Manor Nursing HOme

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Josie	Marian	Chapman	July 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	May 8, 1881	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Suprise, Nebraska	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Shively	Pennsylvania	Cora Crockett	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	none 0	518-26-7411	Nina D Schweser	Coeur d'alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH 5yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Adynamic ileus — 3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 29, 1969 to July 31, 1969 that I last saw the deceased alive on July 31, 1969 and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Hay M.D.	Coeur d alene	8/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-2-1969	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 8 1969	Lorraine K Brush	Bill Huff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 21985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3343
Local Reg. No. 69
Reg. Dist. No. 200

Certificate of Death

RECEIVED
JUL 15 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 4 Days 304
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 324

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Troy
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Gerald
b. (Middle): Edgar
c. (Last): Peterson

4. DATE OF DEATH (Month) (Day) (Year): July 1, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single 1
8. DATE OF BIRTH: Nov. 19, 1904
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Moscow Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Adolph Peterson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Hulda Lagarquist — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-42-3075
17. INFORMANT'S OWN SIGNATURE: X Frank A. Peterson — ADDRESS: Genesee, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of the Stomach — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1949, *to* 7-1, 1969, *that I last saw the deceased alive on* 7-1, 1969, *and that death occurred at* 6:45P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: O Drury 148 — (Degree or title): M.D.
23b. ADDRESS: Troy Idaho
23c. DATE SIGNED: 7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: July 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: July 11, 1969
REGISTRAR'S SIGNATURE: Wayne R Hershari
25. EMBALMER: Donald Ward — LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3344
Local Reg. No. 68
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 719 S. Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Alvin	H.	Crisp	July 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	Jan. 19, 1894	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sign Painter 21	Painting	Granite Falls, North Carolina	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	8	525-34-5895	Gerald Brogmeier	Moscow, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular fibrillation 4109 — INTERVAL BETWEEN ONSET AND DEATH Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial infarction
DUE TO (c) Coronary atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Bleeding duodenal ulcer

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 29 June 1969 *to* 3 July 1969, *that I last saw the deceased alive on* 3 July 1969, *and that death occurred at* 8:25 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. S. Richardson M.D. 1057	Moscow, Idaho	July 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 7, 1969	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10 July 1969	Wayne K Zeiskari	Donald Ward	E-380

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3345
Local Reg. No. 70
Reg. Dist. No. 200

Certificate of Death

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 290
a. COUNTY Latah 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Troy Clinic 114

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Deary
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Alvis b. (Middle) Smith c. (Last) Puckett

4. DATE OF DEATH (Month) July (Day) 8 (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4
8. DATE OF BIRTH March 2, 1886
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) woodsman 17
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rogers, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Bud Puckett BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 519-09-4638
17. INFORMANT'S OWN SIGNATURE X Ralph N. Puckett ADDRESS Portland

18. CAUSE OF DEATH 7824
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Car sickness + constipation — several days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19 55, to 7-8, 19 69 that I last saw the deceased alive on 7-8, 19 69, and that death occurred at 2 P m., from the causes and on the date stated above.*

23a. SIGNATURE Omer H Drum 148 (Degree or title) MD 1
23b. ADDRESS Troy Idaho
23c. DATE SIGNED 7-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE July 11, 1969
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 17 July 1969
REGISTRAR'S SIGNATURE Wayne R Heiskari
25. EMBALMER Donald Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3346
Local Reg. No. 72
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Latah — JUL 28 1969 — 3/5 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow — c. LENGTH OF STAY in this place: 15 days — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Latah — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Viola 290 — d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) — a. (First): Myrtle — b. (Middle): — c. (Last): Hughes

4. DATE OF DEATH — (Month): July — (Day): 11 — (Year): 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: March 3, 1890

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Palouse, Wash.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Redman — BIRTHPLACE: Wisc.

14. MOTHER'S MAIDEN NAME: Sarah Cochrane — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 519-42-3657B

17. INFORMANT'S OWN SIGNATURE: X Myrtle J. Hughes — ADDRESS: Lewiston, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Carcinoma, Breast — rays.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hepatic + Renal Failure bupes.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/3, 1956, to 7/10, 1969, *that I last saw the deceased alive on* 7/10, 1969, *and that death occurred at* 2/a/69 hr, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thos. D. Baird M.D. — 23b. ADDRESS: Moscow, Idaho — 23c. DATE SIGNED: 7/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: July 13, 1969 — 24c. NAME OF CEMETERY OR CREMATORY: Viola Cemetery — 24d. LOCATION (City, town, or county) (State): Viola Idaho

DATE REC'D BY LOCAL REG.: 23 July 1969 — REGISTRAR'S SIGNATURE: Wayne R Heiskari — 25. EMBALMER: Oswald Ward — LICENSE NO.: E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 28 1969

Certificate of Death

STATE OF IDAHO

State File No. 3347
Local Reg. No. 73
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Latah 29 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow — c. LENGTH OF STAY (in this place): 27 Months 102 — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Latah 290 — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Princeton — d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Richard	Eldon	Tribble	July 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed 2	April 14, 1883	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21		Princeton, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dudley C. Tribble	Platte City, Mo.	Cora Nettie Jones	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	8	519-22-1722	Charles A. Bower	Kendrick, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

4189

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1962, *to* June, 1969, *that I last saw the deceased alive on* May, 1969, *and that death occurred at* 6:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward L. Boas MD	Moscow, Idaho	7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 17, 1969	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
24 July 1969	Dwayne R Heiskari	Donald Ward	E-380

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3348
Local Reg. No. 71
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 290 JUL 23 1969
b. CITY OR TOWN Viola
c. LENGTH OF STAY (in this place) 56 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at Home 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN Viola
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Edwin c. (Last) Gray
4. DATE OF DEATH (Month) (Day) (Year) July 13, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 31, 1908
9. AGE (In years last birthday) 61 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY agriculture
11. BIRTHPLACE (State or foreign country) Opportunity, Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Edwin Gray BIRTHPLACE Batesville, Arkansas
14. MOTHER'S MAIDEN NAME Elizabeth Williams BIRTHPLACE Franklin, Arkansas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-3638
17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Viola, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Leukemia — INTERVAL BETWEEN ONSET AND DEATH 6 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 11, 1969, to July 13, 1969, *that I last saw the deceased alive on* July 11, 1969, *and that death occurred at* 8:05 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward J Bodie (Degree or title) MD
23b. ADDRESS Moscow Idaho
23c. DATE SIGNED 7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 16, 1969
24c. NAME OF CEMETERY OR CREMATORY Viola Cemetery
24d. LOCATION (City, town, or county) Viola (State) Idaho

DATE REC'D BY LOCAL REG. 17 July 1969
REGISTRAR'S SIGNATURE Wayne K Weiskari
25. EMBALMER Donald Ward
LICENSE NO. E-380

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 12 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3349
Local Reg. No. 77
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH a. COUNTY: Latah 290	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho b. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Deary 301	c. LENGTH OF STAY (in this place): 1 day
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 Mi. E. of Deary 000	d. STREET ADDRESS (If rural, give location): 623 - 10th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Ferdinand	c. (Last) Hiebert	4. DATE OF DEATH (Month) 7 (Day) 14 (Year) 69
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: 9-22-1947	9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 06 General Maintenance	10b. KIND OF BUSINESS OR INDUSTRY: P.F.I.	11. BIRTHPLACE (State or foreign country): Washington	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: James R. Roos	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Helen Russell	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1	(If yes, give war or dates of service): Nat'l Guard 2 Date Unknown 9258	16. SOCIAL SECURITY: 539-42-7488	17. INFORMANT'S OWN SIGNATURE: X John Hiebert	ADDRESS: Pomeroy Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) electric shock — INTERVAL BETWEEN ONSET AND DEATH: assured.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify): 1 accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.): power station 290	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Deary 13 Latah 290 Idaho	
21d. TIME OF INJURY (Month) 7 (Day) 14 (Year) 69 (Hour) 5 p.m.	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? shot hi voltage wire & fell on him	

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 5 p.m., from the causes and on the date stated above.*

23a. SIGNATURE: J. Kirkman 583	(Degree or title): Coroner	23b. ADDRESS: Moscow Idaho	23c. DATE SIGNED: 7/21/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial	24b. DATE: 7-18-69	24c. NAME OF CEMETERY OR CREMATORY: City	24d. LOCATION (City, town, or county) (State): Pomeroy, Washington
DATE REC'D BY LOCAL REG.: 6 Aug 1969	REGISTRAR'S SIGNATURE: Wayne R. Heiskari	25. EMBALMER: Andy Reinland, Jr.	LICENSE NO.: QL-890

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 27 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 27 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3350
Local Reg. No. 74
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JUL 28 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow Rur
c. LENGTH OF STAY (in this place): 6 Mo. 20 Days 206
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 328

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
d. STREET ADDRESS (If rural, give location): 11 Miles North of Potlatch

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	GRACE	ELLEN	PARNELL	July 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	Aug. 13, 1891	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	Own Home	Gibbs, Missouri	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marion Hicks	Indiana	Maryville Barnhill	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 3	539-46-6356	Dorothy Kibble	Potlatch, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Adenocarcinoma Rectum — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* October, 1958, *to* 7-22, 1969, *that I last saw the deceased alive on* 7-22, 1969, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lloyd C. Walden MD	Moscow, Idaho	7-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-24-1969	Freeze Cemetery	Latah Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Wayne R. Heiskari	H. E. Kimball	E269

FIRM NAME: Kimball Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3351
Local Reg. No. 75
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 29 Latah — 319
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (In this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 405 No. Hayes St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	B.	Benson	July	23	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	married 3	March 2, 1903	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
store owner 22	Hardware	Tower, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Olaf Benson	Sweden	Ida Lillie	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	518-36-1201	X Emmett E. Davis	Moscow, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis, origin unknown — INTERVAL BETWEEN ONSET AND DEATH: 5 Month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1999

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept, 1957, *to* July 23, 1969, *that I last saw the deceased alive on* July 22, 1969, *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. Odams MD		Moscow, Idaho	7/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 25, 1969	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
29 July 1969	Wayne R Weishair	E. Pete Albertson	E-525

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: AUG 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3352
Local Reg. No. 76
Reg. Dist. No. 200

BIRTH NO.

RECEIVED
AUG 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 29 | 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 526 West 1st

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ruth	Harman	Martin	July	28	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	April 3, 1915	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Allendale, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Louis A. Harman	Missouri	Zula Z. Wilkinson	Allendale, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 533-01-2445
17. INFORMANT'S OWN SIGNATURE: x C. E. Martin — ADDRESS: Moscow, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	ACUTE MYOCARDIAL INFARCTION	1 Hour
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Myocardial Infarction	3 days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 25, 1969, *to* July 28, 1969, *that I last saw the deceased alive on* July 28, 1969, *and that death occurred at* 4:20 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Moscow, Idaho	30 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 30, 1969	Sunset Memorial	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6 Aug 1969	Maynard Hershart	E. Pete Albertson	E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 22 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

OCT 16 1980

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 12 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3353
Local Reg. No. 78
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN: Moscow
c. LENGTH OF STAY (in this place): 3-1/3 yrs. 103
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah County Nursing Home 115

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Juliaetta
d. STREET ADDRESS (If rural, give location): rural

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VIOLA	ELIZABETH	BROWNING	31 July 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	21 June 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Osa, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harrison Hemphill	no record	Sarah ? ?	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 2 0	534 12 8679	X Jack V Brower	Juliaetta, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atonic Brain Syndrome	4 yrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gangrene of Foot	2 Months
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1967, *to* July, 1969, *that I last saw the deceased alive on* July 26, 1969, *and that death occurred at* 11:15 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
788 Edward L Bass MD	Moscow Idaho	8-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	2 Aug 1969	Juliaetta City Cemetery	Juliaetta, Latah Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8 August 1969	Wayne R Heiskari	W E Black	E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 8 1969 Bureau of Vital Statistics

State File No. 3354
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Near Kriley Gulch Mile Post #320.00
LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Wallace
b. (Middle) Sherman
c. (Last) Walchli

4. DATE OF DEATH (Month) (Day) (Year) April 13, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 5/21/21
9. AGE (In years last birthday) 47
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender 23
10b. KIND OF BUSINESS OR INDUSTRY ------
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hans Walchli
BIRTHPLACE Terre Haute, Ind.
14. MOTHER'S MAIDEN NAME Beatrice Slavin
BIRTHPLACE Carmen, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1
(If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 519-16-0863
17. INFORMANT'S OWN SIGNATURE Elvin J. Albiston
ADDRESS Salmon, Idaho

18. CAUSE OF DEATH 8160
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Assumed asphyxiation by drowning

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (body not recovered)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) U.S. Highway #93 06
21c. (CITY, TOWN, OR TOWNSHIP) Near North Fork 13 (COUNTY) Lemhi 300 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) April 13, 1969 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? See attached papers

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)
23b. ADDRESS Salmon, Idaho
23c. DATE SIGNED 7/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 8-8-69
REGISTRAR'S SIGNATURE W W Benson
25. EMBALMER
LICENSE NO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

7-18-69

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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ADDITIONAL REMARKS by Physician.....

.....

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RECEIVED
AUG 8 1969
Bureau of Vital Statistics

A F F I D A V I T

STATE OF IDAHO

County of Lemhi--SS

Marianne Stoddard, being first duly sworn, deposes and says:

That she is a student at the Salmon High School at Salmon, Idaho, and is 16 years of age; that she and Bret Barsalou were eating at the Triangle C at North Fork, Idaho, at about 9 o'clock p.m. on April 13, 1969; that she and the said Bret Barsalou saw W.S. Walchli, sometimes known as Sherman Walchli, at that time and place and visited with him and when affiant and Bret Barsalou started to drive back to Salmon, Idaho, the said W.S.Walchli also left the Triangle C and drove behind them and they observed his headlights following them until they reached the area known as Wagonhammer and Kriley Gulch; said affiant and the said Bret Barsalou continued on their way to Salmon, Idaho, and they did not know until the following day that he had gone off the highway and in to the Salmon River; the said W. S. Walchli was alone when he left the Triangle C and was driving approximately 35 miles or 40 miles per hour when he was following affiant and Bret Barsalou; he was driving a Rambler automobile reported to be the property of Milton Olsen.

Marianne Stoddard

Subscribed and sworn to before me this 29th day of April, 1969.

Fredrick Hughes Snook

Notary Public for Idaho, Residing at Salmon, Idaho.

FRED H. SNOOK
LAWYER
SALMON, IDAHO

RECEIVED
AUG 8 1969
Bureau of Mines

A F F I D A V I T

STATE OF IDAHO

County of Lemhi--ss

Marianne Stoddard, being first duly sworn, deposes and says:

That she is a student at the Salmon High School at Salmon, Idaho, and is 16 years of age; that she and Bret Barsalou were eating at the Triangle C at North Fork, Idaho, at about 5 o'clock p.m. on April 13, 1969; that she and the said Bret Barsalou saw W.S. Walchli, sometimes known as Sherman Walchli, at that time and place and visited with him and when affiant and Bret Barsalou started to drive back to Salmon, Idaho, the said W.S.Walchli also left the Triangle C and drove behind them and they observed his headlights following them until they reached the area known as Wagonhammer and Kirley Gulch; said affiant and the said Bret Barsalou continued on their way to Salmon, Idaho, [illegible] the highway and in to the Salmon River; the said W. S. Walchli was alone when he left the Triangle C and was driving approximately 35 miles or 40 miles per hour when he was following affiant and Bret Barsalou; he was driving a Rambler automobile reported to be the property of Milton Olsen.

Marianne Stoddard

Subscribed and sworn to before me this 29th day of April, 1969.

Notary Public for Idaho, Residing at Salmon, Idaho.

FRED H. SIDDOK
LAWYER
SALMON, IDAHO

RECEIVED
AUG 8 1969
Bureau of Vital Statistics

REPORT BY ELVIN J. ALBISTON

I, the undersigned, Elvin J. Albiston, do hereby certify that I am an officer of the Idaho State Police Force; that I investigated an accident on April 14, 1969, when I was called about 2.30 p.m. on said day by Arch Wirth, a ranger from the Indianola Station near North Fork, Idaho, who had seen an upturned car in the Salmon River; that I arrived at the scene about 3.00 p.m. of said day and found the car about 13½ miles North of Salmon in the Salmon River at Mile Post 320.00 which is near the Kriley Gulch area; a wrecker removed the vehicle and there was no person or bodies in the vehicle.

The vehicle was a 1959 Rambler with Idaho license No. 2L-1284 and belonged to Milton Olson of Salmon, Idaho.

My investigation revealed that the driver had been W. S. Walchli, sometimes known as Sherman W. Walchli, and that he had left the North Fork Cafe between 9.00 o'clock and 9.15 p.m. on April 13, 1969, and started toward Salmon. The accident was about 7 miles from North Fork between North Fork and Salmon. The body of said W.S. Walchli has not yet been recovered from the Salmon River.

Dated this 29th day of May, 1969.

Elvin J. Albiston

FRED H. SNOOK
LAWYER
SALMON, IDAHO

RECEIVED
AUG 8 1969
Bureau of Vital Statistics

REPORT BY ELVIN J. ALBISTON

I, the undersigned, Elvin J. Albiston, do hereby certify that I am an officer of the Idaho State Police Force; that I investigated an accident on April 14, 1969, when I was called about 2.30 p.m. on said day by Arch Wirth, a ranger from the Indianola Station near North Fork, Idaho, who had seen an upturned car in the Salmon River; that I arrived at the scene about 3.00 p.m. of said day and found the car about 13½ miles North of Salmon in the Salmon River at Mile Post 320.00 which is near the Kriley Gulch area; a wrecker removed the vehicle and there was no person or bodies in the vehicle.

The vehicle was a 1959 Rambler with Idaho license No. 2L-1284 and belonged to Milton Olson of Salmon, Idaho.

My investigation revealed that the driver had been W. S. [illegible] sometimes known as Sherman [illegible] Walchli [illegible] left the North Fork Cafe between 9.00 o'clock and 9.15 p.m. on April 13, 1969 and started toward Salmon. The accident was about 7 miles from North Fork between North Fork and Salmon. The body of said W.S. Walchli has not yet been recovered from the Salmon River.

Dated this 29th day of May, 1969.

[signature]

JUN 7 1972

RECEIVED
JUL 17 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3355
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY (Salmon) Lemhi County 300 530
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
c. LENGTH OF STAY (in this place) ½ hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Steele Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baker (29 years)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Quinn b. (Middle) W c. (Last) Riggan

4. DATE OF DEATH (Month) (Day) (Year) July 13, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 23
8. DATE OF BIRTH May 21, 1902
9. AGE (In years last birthday) 67 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Teton City, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edmond Frank Riggan
BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Ida Clark
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 2 0
16. SOCIAL SECURITY NO. 519 38 6297
17. INFORMANT'S OWN SIGNATURE Mrs. Quinn Riggan ADDRESS Baker, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-31-69, 19___, *to* 7-13, 19 69, *that I last saw the deceased alive on* 7-13, 19 69, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Salmon Idaho
23c. DATE SIGNED 7-15 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 16, 1969
24c. NAME OF CEMETERY OR CREMATORY Victor
24d. LOCATION (City, town, or county) (State) Victor, Idaho

DATE REC'D BY LOCAL REG. July 15, 1969
REGISTRAR'S SIGNATURE Viola E Johnson
25. EMBALMER Delbert C Jones
LICENSE NO. E 369
FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3356
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 600
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casabello Estate 272

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mackay
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Rose
b. (Middle): Ella
c. (Last): Nowacki

4. DATE OF DEATH (Month) (Day) (Year): July 22, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Aug. 18, 1887
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hotel Owner 22
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (State or foreign country): Barton, Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Geroge Nowacki — BIRTHPLACE: Pozen, Poland
14. MOTHER'S MAIDEN NAME: Margaret Bliner — BIRTHPLACE: Near Warsaw, Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: C. W. Marvel — ADDRESS: Arco, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-16-, 1964, *to* 7-22, 1969, *that I last saw the deceased alive on* 6-28, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. Johnson 263 M.D.
23b. ADDRESS: Box 769 Salmon, Idaho
23c. DATE SIGNED: 7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem-Burial
24b. DATE: 7-25-69
24c. NAME OF CEMETERY OR CREMATORY: Mt. McCaleb
24d. LOCATION (City, town, or county) (State): Mackay, Idaho

DATE REC'D BY LOCAL REG.: 7-30-69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones — LICENSE NO. E369
FIRM NAME: Jones Funeral Home, Salmon

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3357
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lemhi
LENGTH OF STAY (in this place) 43 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Tobias ranch home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lemhi
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Ethel b. (Middle) Margaret c. (Last) Tobias
4. DATE OF DEATH (Month) (Day) (Year) July 26, 1969
5. SEX Female
6. COLOR OR RACE Whit e
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 14, 1907
9. AGE (In years last birthday) 61 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) South Bend, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Arthur Clarence Wooley BIRTHPLACE Nebraska
14. MOTHER'S MAIDEN NAME Annabelle Ireland BIRTHPLACE Nebraska
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 2 0
16. SOCIAL SECURITY NO. no
17. INFORMANT'S OWN SIGNATURE Champ Tobias ADDRESS Lemhi, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction 4709

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) coronary artery disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-26-69, 19___, *to* 7-26-69, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Box 769 Salmon, Idaho
23c. DATE SIGNED 7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-30-69
24c. NAME OF CEMETERY OR CREMATORY Salmon
24d. LOCATION (City, town, or county) Salmon, Idaho (State)

DATE REC'D BY LOCAL REG. 7-30-69
REGISTRAR'S SIGNATURE Viola E. Johnson
25. EMBALMER Delbert C. Jones
LICENSE NO. E 369
FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-62021

DUTIES: JUN 28 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures MAY 20 1975 of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3358
Local Reg. No. 686
Reg. Dist. No. 430

RECEIVED JUL 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
LENGTH OF STAY (in this place) -000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 240 Woodriver Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
KATE	S.	ALEXANDER	July	7,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	March 8, 1882	87	3	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Belgrade, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas T. Cooper BIRTHPLACE Youngleads Co, Canada
14. MOTHER'S MAIDEN NAME Emile J. Dryer BIRTHPLACE Hickory Grove, Ill.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no 2
16. SOCIAL SECURITY NO. 518-20-1372-A
17. INFORMANT'S OWN SIGNATURE X Grace A Alexander ADDRESS Shoshone

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis + Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 5yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4379

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from May, 1968, to July 7, 1969, that I last saw the deceased alive on July 3, 1969, and that death occurred at 10:25 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
386 [illegible] M.D.	Box 68 Rexburg Idaho	7-10 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-10-1969	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-12-69	Francis M. Bergin	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3359
Local Reg. No. 687
Reg. Dist. No. 430

BIRTH NO.

RECEIVED
JUL 17 1969
Bureau of Vital Statistics

320

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY OR TOWN: Shoshone
c. LENGTH OF STAY IN THIS PLACE: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Woodriver Convalescent Home 320

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl-Castleford aera
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	MARY	ANGELINE	WEBB	July	11,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	May 28, 1882	87	1	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Marble, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Franklin Hudspeth — BIRTHPLACE: Madison Co. Arkansas
14. MOTHER'S MAIDEN NAME: Margaret Jane Howard — BIRTHPLACE: Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): No 0
16. SOCIAL SECURITY NO.: 518-11-8336-D
17. INFORMANT'S OWN SIGNATURE: X Imogene Helsley — ADDRESS: Shoshone, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bleeding Duodenal Ulcer — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

5320

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 19, 1969, *to* July 11, 1969, *that I last saw the deceased alive on* July 9, 1969, *and that death occurred at* 1:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
386 [signature] MD	Box 68 Shoshone Idaho	7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-14-1969	Buhl Cemetery	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-15-69	Frances M Bergin	Frances M Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3360
Local Reg. No. 688
Reg. Dist. No. 430

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (in this place): 4 months 204
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural route No. 1
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle):
c. (Last): EGERSDORF

4. DATE OF DEATH (Month) (Day) (Year): July 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 25, 1889
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months 7, Days 3 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert Strasrypka — BIRTHPLACE: Prague, Czechoslovakia
14. MOTHER'S MAIDEN NAME: Mary Black — BIRTHPLACE: Czechosloavakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): no 0
16. SOCIAL SECURITY NO.: 519-44-7571D
17. INFORMANT'S OWN SIGNATURE: X Jerry Egersdorf — ADDRESS: Gooding, Idaho

18. CAUSE OF DEATH 4339
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 23, 1969 *to* July 28, 1969, *that I last saw the deceased alive on* July 24, 1969, *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 386 [signature] 1
23b. ADDRESS: Box 68 Shoshone Idah
23c. DATE SIGNED: 8-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7-31, 1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 8-6-69
REGISTRAR'S SIGNATURE: Francis M Bergin
25. EMBALMER: Francis M Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 12 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3361
Local Reg. No. 689
Reg. Dist. No. 430

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (in this place): 8 yrs 108
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser 441
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): L.
c. (Last): Barton

4. DATE OF DEATH (Month) (Day) (Year): July 29, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 20, 1873
9. AGE (In years last birthday): 96 — IF UNDER 1 YEAR: Months 0, Days 9 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer and electrician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Iberia, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNK 29
BIRTHPLACE: UNK.
14. MOTHER'S MAIDEN NAME: UNK
BIRTHPLACE: UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 (If yes, give war or dates of service): no 0
16. SOCIAL SECURITY NO.: 519-20-1838-A
17. INFORMANT'S OWN SIGNATURE: X Audrey E Farnham
ADDRESS: Ketchum, Idaho

18. CAUSE OF DEATH 4379
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arterio Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1961, *to* July 29, 1969, *that I last saw the deceased alive on* July 29, 1969, *and that death occurred at* 11:55 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: 386 [signature] (Degree or title): 1
23b. ADDRESS: Box 68 Shoshone Idaho
23c. DATE SIGNED: 8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-2-1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser, Idaho

DATE REC'D BY LOCAL REG.: 8-6-69
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3362
Local Reg. No. 35
Reg. Dist. No. 6-30

RECEIVED
Bureau of Vital Statistics
JUL 16 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Rexburg
c. LENGTH OF STAY (If hospital or institution): 1 week

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 342 W. 1st North

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial

331 307 123 360

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELIZA	PEARL	PALMER	July 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	Sept. 21, 1900	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 61	Home	Benjamin, Utah.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis Richard Bird	Mendon, Utah	Martha Ellen Brady	Fairview, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	None 0	519-38-3232	Shirley Johnson	Lorenzo, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 31, 1966, *to* July 1, 1969, *that I last saw the deceased alive on* July 1, 1969, *and that death occurred at* 6:30P m., *from the causes and on the date stated above.*

409

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Blaine H. Hawkes	M.D.	Rexburg, Idaho.	7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 5, 1969	Milo Cemetery	Milo Bonneville Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-11-69	Lena Flamm	Bruce A. Eckersell Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 12 2009

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3363
Local Reg. No. 36
Reg. Dist. No. 630

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 331 Madison
JUL 16 1969
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY IN THIS PLACE: 4 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 133 Madison Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 331 Rexburg
d. STREET ADDRESS (If rural, give location): 230 East 1st South

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	OMER	SAMUEL	CORDON	July 5 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Aug. 7, 1885	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Insurance Agent 24	Insurance	Willard Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Albert Cordon	Willard Ut.	Sally Agnes Call	Willard Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	none 0	518-36-3785	Barbara L. Ellis	Lorenzo, Idaho

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 28 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — several years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1960, *to* 7-5, 1969, *that I last saw the deceased alive on* 7-5, 1969, *and that death occurred at* 1 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
413 Leslie J. Ellsworth MD	Rexburg Idaho	7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/9/69	Rigby Pioneer	Rigby Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-11-69	Leona Flamm	Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

APR 4 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3364
Local Reg. No. 44
Reg. Dist. No. 630

BIRTH NO. RECEIVED

1. PLACE OF DEATH
a. COUNTY: Madison 330 JUL 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Route #1 Boreanzo Vital Statistics
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route #1, Lorenzo 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RFD. #2 Idaho Falls
d. STREET ADDRESS (If rural, give location): RFD #2, Box 66,

3. NAME OF DECEASED (Type or Print)
a. (First): HERMAN
b. (Middle): DAVID PAUL
c. (Last): GOHR

4. DATE OF DEATH (Month) (Day) (Year): July 5, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 21, 1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 29 Farmer, retired
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Wittamore, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alexander Gohr, BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Amelia Wagoner, BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 24 9927
17. INFORMANT'S OWN SIGNATURE: Nellie M. Gohr. ADDRESS: Ida. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): progressive miocardiac condition — INTERVAL BETWEEN ONSET AND DEATH: 7 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: n/a
19b. MAJOR FINDINGS OF OPERATION: n/a
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): n/a
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): NW¼, Sec22, T5N, R38E, Madison Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): n/a m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: n/a

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 2:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 583 Coroner 4
23b. ADDRESS: Route #1, RExburg, Idaho
23c. DATE SIGNED: 14 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Cedar Butte Cemetery
24d. LOCATION (City, town, or county) (State): Annis, Idaho, Jefferson

DATE REC'D BY LOCAL REG.: 7-14-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: [signature]
LICENSE NO.: E #387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck-Sullivan Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3365
Local Reg. No. 43
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

1. PLACE OF DEATH 330
a. COUNTY Madison JUL 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Thornton Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison 330
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Thornton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Neils b. (Middle) Marinus c. (Last) Hansen
4. DATE OF DEATH (Month) July (Day) 10, (Year) 1969
5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Dec. 24, 1877
9. AGE (In years last birthday) 91 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ortoft, Volstrop Hjarring, Denmark
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Neils Christian Hansen BIRTHPLACE Ortoft, Volstrop Hjarring, Denmark
14. MOTHER'S MAIDEN NAME Anna Margaret Neilson BIRTHPLACE Ortoft, Volstrop Hjarring, Denmark
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 518-48-0667
17. INFORMANT'S OWN SIGNATURE Glen R Hansen ADDRESS 334 West 2 So. Rigby, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1957, *to* July 10, 1969, *that I last saw the deceased alive on* July 8, 1969, *and that death occurred at* 7:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE 442 M. F. Rigby Mrs (Degree or title)
23b. ADDRESS Redburg Idaho
23c. DATE SIGNED July 10 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/14/69
24c. NAME OF CEMETERY OR CREMATORY Sutton Cemetery
24d. LOCATION (City, town, or county) (State) Archer, Madison, Idaho

DATE REC'D BY LOCAL REG. 7-12-69
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER Russel Flamm
LICENSE NO. E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3366
Local Reg. No. 46
Reg. Dist. No. 6 30

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Madison 330 JUL 24 1969
b. CITY OR TOWN Rexburg. Rural (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Hiway 191 -3 miles North Rexburg.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Teton City
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LYNN	K.	GOULD	July 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Never Married	Jan 30, 1952	17				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student and Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: 03
11. BIRTHPLACE (State or foreign country): Ashton, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Gould — BIRTHPLACE: Wilford, I daho
14. MOTHER'S MAIDEN NAME: Alta Davis — BIRTHPLACE: Wilford, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 520-60-6267
17. INFORMANT'S OWN SIGNATURE: Walter Gould — ADDRESS: Teton, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severed Aorta — INTERVAL BETWEEN ONSET AND DEATH: 45 seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) crushed chest
DUE TO (c) auto accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: n/a
19b. MAJOR FINDINGS OF OPERATION: n/a
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): MP#157.2,US191
21c. (CITY, TOWN, OR TOWNSHIP) 3 Miles North, Rexburg, (COUNTY) Madison (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 13,1969 1:15 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto accident

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 1:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 Coroner 4		Box 13, Rexburg, Idaho	15July1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	17 June 69	Wilford Cemetery	St. Anthony, Fremont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-69	Leona Hansen	M. D. Hansen	E-354

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hansen Memorial chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3367
Local Reg. No. 43
Reg. Dist. No. 630

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 24 1969

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Clarence Ezra
b. (Middle):
c. (Last): Fisher

4. DATE OF DEATH (Month) July (Day) 19 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 6, 1897
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hibbard, Idaho
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Henry Fisher — BIRTHPLACE: Lohningen, Switzerland
14. MOTHER'S MAIDEN NAME: Mary Ann Hildt — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Verla Fisher Davis — ADDRESS: Sugar City Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

342X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paralysis Agitans — INTERVAL BETWEEN ONSET AND DEATH: 10 year.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* July 19, 1969, *that I last saw the deceased alive on* July 7, 1969, *and that death occurred at* 3:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 409 — **23b. ADDRESS**: Rexburg Idaho — **23c. DATE SIGNED**: 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/23/69
24c. NAME OF CEMETERY OR CREMATORY: Rexburg Cemetery
24d. LOCATION (City, town, or county) (State): Rexburg, Madison, Idaho

DATE REC'D BY LOCAL REG.: 7-21-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: James Flamm — **LICENSE NO.**: E-477

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3368
Local Reg. No. 47
Reg. Dist. No. 630

BIRTH NO.

RECEIVED AUG 12 1969 STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Madison 331 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 133

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony, Rural
d. STREET ADDRESS (If rural, give location): RFD#1

3. NAME OF DECEASED (Type or Print): a. (First) NEIL b. (Middle) SEVERIN c. (Last) SWENSEN

4. DATE OF DEATH (Month) (Day) (Year): July 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married 3	23 June 1906	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer and Sheepman 04
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed 11
11. BIRTHPLACE (State or foreign country): Mt. Pleasant, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Severin Swensen — BIRTHPLACE: Mt. Pleasant, Utah
14. MOTHER'S MAIDEN NAME: Ingeborg B. Olsen — BIRTHPLACE: Bergen, Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): 3
16. SOCIAL SECURITY NO.: 519-03-5052
17. INFORMANT'S OWN SIGNATURE: Wanda Swensen — ADDRESS: St. Anthony, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 2509

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Diabetes Mellitus — 4 years
DUE TO (c) Myocardial Disease — 6 months

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 65, *to* 7-29, 1969, *that I last saw the deceased alive on* 7-29, 1969, *and that death occurred at* 12:15 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 233 — 23b. ADDRESS: Rexburg, Idaho — 23c. DATE SIGNED: 4 August 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1st August 69
24c. NAME OF CEMETERY OR CREMATORY: Wilford Cemetery
24d. LOCATION (City, town, or county) (State): St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.: 8-8-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: M. D. Hansen — LICENSE NO.: E-354

FIRM NAME HANSEN MEMPRIAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3369
Local Reg. No. 59
Reg. Dist. No. 4-10

BIRTH NO.

RECEIVED
AUG 20 1969

1. PLACE OF DEATH
a. COUNTY 340 Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert 340

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 125
d. STREET ADDRESS (If rural, give location) 1024 Third Street

3. NAME OF DECEASED (Type or Print) a. (First) FRANCES b. (Middle) c. (Last) HAGER

4. DATE OF DEATH (Month) (Day) (Year) March 28, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH August 9, 1888
9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Taos, New Mexico
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Lawrence BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Ella unknown BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - 0 - -
16. SOCIAL SECURITY NO. 519-56-7048
17. INFORMANT'S OWN SIGNATURE Russell Anderson ADDRESS Pocatello, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH 2-3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary fibrosis and generalized Arteriosclerosis — 2 yrs yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Sept, 1966, *to* March 28, 1969, *that I last saw the deceased alive on* March 28, 1969, *and that death occurred at* 10:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 740 H W Crawford MD (Degree or title)
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 8 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE March 31, 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) Rupert (State) Idaho

DATE REC'D BY LOCAL REG. 8-19-69
REGISTRAR'S SIGNATURE Mary Ellen Larson
25. EMBALMER Charles H Parsons
LICENSE NO. E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3370
Local Reg. No. 45
Reg. Dist. No. 450

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340 JUL 16 1969 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
LENGTH OF STAY (In this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka County Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	EDWARD	TOEVS	July 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Widowed 2	Nov. 6, 1888	80	7	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant 22	Grocery & Dry Goods	Newton, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Toevs	Germany	Anna Wiebe	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2		518-09-3759	A O Toevs	Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebrovascular accident	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Bronchopneumonia	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1 June, 1969, to 5 July, 1969, that I last saw the deceased alive on 5 July, 1969, and that death occurred at 11:40 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. W. Crawford MD	Rupert, Idaho	10 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	7-8-69	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	Mary Ellen Carlson	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 5 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3371
Local Reg. No. 47
Reg. Dist. No. 450

Certificate of Death

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 1 day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital 135

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 809-6th Street

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): C.
c. (Last): Hadley

4. DATE OF DEATH (Month) (Day) (Year): July 6 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan 8 1882
9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tompson Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Hadley
BIRTHPLACE: New York State
14. MOTHER'S MAIDEN NAME: Lillian Jesseph
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2
(If yes, give war or dates of service): none 0
16. SOCIAL SECURITY NO.: 519-38-5241
17. INFORMANT'S OWN SIGNATURE: Lita M. Hadley
ADDRESS: Rupert Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASCVD
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* I did not see this patient alive, *19*___, *that I last saw the deceased alive on* _____, *19*___, *and that death occurred at* _____ *m., from the causes and on the date stated above.* I talked to the family on phone

23a. SIGNATURE (Degree or title): 253 Clark Humphrey MP
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 7-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 9 1969
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: 7-21-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Robert C. Walk
LICENSE NO.: E 294
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 12 1997

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Or Kampling

RECEIVED JUL 28 1969

Certificate of Death

STATE OF IDAHO

State File No. 3372
Local Reg. No. 49
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 4 months 304
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 135

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 5th and G Street-Wherry Apt.

3. NAME OF DECEASED (Type or Print)
a. (First) Manuel
b. (Middle)
c. (Last) Bengoechea

4. DATE OF DEATH (Month) (Day) (Year) July 7 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH August 5 1884
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ybarain-Jelua, Spain
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joe Bengoechea — BIRTHPLACE Spain
14. MOTHER'S MAIDEN NAME May Omar — BIRTHPLACE Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 — (If yes, give war or dates of service) none 0
16. SOCIAL SECURITY NO. 518-40-9535
17. INFORMANT'S OWN SIGNATURE Ax Flora Aspiazu — ADDRESS Rupert Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1991

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suspected but unproven CA. — INTERVAL BETWEEN ONSET AND DEATH: yes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ?

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* death, 19__, *that I last saw the deceased alive on* July 7, 1969, *and that death occurred at* 10 00 *A.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 253 Ben K. Humphrey MD
23b. ADDRESS 645 5th Street - Rupert Ida
23c. DATE SIGNED 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 10 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 7-28-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Charles H Persons
LICENSE NO. E-494

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Walk Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Ex Outlier

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3373
Local Reg. No. 48
Reg. Dist. No. 450

BIRTH NO.

JUL 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 340
a. COUNTY Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 135

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 914 7th street

3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) c. (Last) Duffin

4. DATE OF DEATH (Month) (Day) (Year) July 7 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 27 1889
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Toquerville Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Mathew Stone Batty, England BIRTHPLACE
14. MOTHER'S MAIDEN NAME Martha Elizabeth Willis, BIRTHPLACE Cedar City Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) none 0
16. SOCIAL SECURITY NO. 518-09-0742
17. INFORMANT'S OWN SIGNATURE D Velva D. Moller ADDRESS Rupert

2421

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Heart Fa~~ Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Not known

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ~~Tyro~~ Thyrotoxicosis — about 2½ yrs
DUE TO (c) Nodular goitre — Many years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Senile Changes.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 20, 1964, *to* July 7, 1969, *that I last saw the deceased alive on* July 6, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 127 A F Dalley (Degree or title) MD 1
23b. ADDRESS 702 G St Rupert Ida
23c. DATE SIGNED 7/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE July 10 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 7-21-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Robert C Walk
LICENSE NO. E 294

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 2 4 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3374
Local Reg. No. 50
Reg. Dist. No. 450

RECEIVED JUL 29 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Minidoka (340) — b. CITY OR TOWN: Heyburn — c. LENGTH OF STAY (in this place): 1 year (181) — d. FULL NAME OF HOSPITAL OR INSTITUTION: 731 18th St. (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Minidoka — c. CITY OR TOWN: Heyburn (340) — d. STREET ADDRESS (If rural, give location): 731 18th St.

3. NAME OF DECEASED (Type or Print) — a. (First): Mary — b. (Middle): Ellen — c. (Last): Warburton

4. DATE OF DEATH: (Month) (Day) (Year): July 13, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: August 23, 1889

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: housework

11. BIRTHPLACE (State or foreign country): Grouse Creek, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Lee — BIRTHPLACE: Tooele, Utah

14. MOTHER'S MAIDEN NAME: Mary Ann Beckam — BIRTHPLACE: Grantsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): * 0 * 3959

16. SOCIAL SECURITY NO.: 529-50-8103-A

17. INFORMANT'S OWN SIGNATURE: Hannah Rae Rupert — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): acute myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): aortic Stenosis

DUE TO (c): decompensation — ?

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): none

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1962, 19__, *to* 7-13-, 1969, *that I last saw the deceased alive on* 7-9-, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: R Sutton — (Degree or title): MD — 23b. ADDRESS: Burley Idaho — 23c. DATE SIGNED: 7-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 24b. DATE: 7/17/69 — 24c. NAME OF CEMETERY OR CREMATORY: Brigham City Cemetery — 24d. LOCATION (City, town, or county) (State): Brigham City, Utah

DATE REC'D BY LOCAL REG.: 7-28-69 — REGISTRAR'S SIGNATURE: Mary Ellen Gardner

25. EMBALMER: Jerry K. Lauer — LICENSE NO.: E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3375
Local Reg. No. 46
Reg. Dist. No. 450

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 JUL 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Minidoka Memorial Hosp. 125

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Texas 44
b. COUNTY Maverick 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eagle Pass
d. STREET ADDRESS (If rural, give location) 745 Medina Street

3. NAME OF DECEASED (Type or Print)
a. (First) Prudencio
b. (Middle)
c. (Last) HERNANDIZ

4. DATE OF DEATH (Month) (Day) (Year) July 16, 1969

5. SEX Male
6. COLOR OR RACE Spanish
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 28, 1904
9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Mexico
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Hernandez BIRTHPLACE Mexico
14. MOTHER'S MAIDEN NAME Josephephina Sanches BIRTHPLACE Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) - - 0 - -
16. SOCIAL SECURITY NO. 380-16-3720
17. INFORMANT'S OWN SIGNATURE ADDRESS Eagle Pass, Tex.

402X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Ventricular heart failure and acute pulmonary edema

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Heart, left ventricular hypertrophy
DUE TO (c) History of hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive *, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 588 Robert C Walk
23b. ADDRESS 710-6th St Rupert Idaho
23c. DATE SIGNED 7-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE July 18, 1969
24c. NAME OF CEMETERY OR CREMATORY Eagle Pass Cemetery
24d. LOCATION (City, town, or county) (State) Eagle Pass, Texas

DATE REC'D BY LOCAL REG. 7-17-69
REGISTRAR'S SIGNATURE Mary Ellen Cadwell
25. EMBALMER Charles H Persons
LICENSE NO. E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 1 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 2 7 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
JUL 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3376
Local Reg. No. 57
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital 135

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 1501 'G' Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ROBS	CLIFTON	PHILLIPS	July	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	September 15, 1895	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Head Time keeper 10	Union Pacific R. R.	Soldier Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert B. Phillips		Sarah Sevier	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War I 3	712-03-1790	Dr. Robert C. Phillips	Rupert, Idaho

1538

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: not known

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis from Ca of Colon — not known
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-22- , 19 67 *to* July 22 , 19 69, *that I last saw the deceased alive on* July 22 , 19 69, *and that death occurred at* 5:45 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. F. Dalley MD	Rupert, Idaho	July 24, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 24, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-28-69	Mary Ellen Carter	Jack Henderson	E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

JUL 3 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3377
Local Reg. No. 32
Reg. Dist. No. 450

RECEIVED AUG - 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Minidoka (340) — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert (123) — c. LENGTH OF STAY (in this place): 23 years — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. # 4 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Minidoka — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert 340 — d. STREET ADDRESS (If rural, give location): Rt. # 4

3. NAME OF DECEASED (Type or Print) — a. (First): Erma — b. (Middle): H. — c. (Last): Peterson

4. DATE OF DEATH (Month) (Day) (Year): July 25, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Oct. 23, 1913

9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Oakley, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Albert H. Hale — Farmington, Utah

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Lucile Pettigrew — Casey, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no 2 none 8

16. SOCIAL SECURITY NO.: 518-24-5094

17. INFORMANT'S OWN SIGNATURE: Harold A. Peterson — ADDRESS: Rupert, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Dissecting aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Rheumatic heart disease — many years.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Cardiac surgery 1957

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 24 July, 1969, *to* 25 July, 1969, *that I last saw the deceased alive on* 24 July, 1969, *and that death occurred at* 500 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. W. Crawford (340) — (Degree or title): MD — 23b. ADDRESS: Rupert Idaho — 23c. DATE SIGNED: 28 July 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 7/28/69 — 24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery — 24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: 7-30-69 — REGISTRAR'S SIGNATURE: Mary Ellen Larson — 25. EMBALMER: [signature] — LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 24 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3378
Local Reg. No. 13
Reg. Dist. No. 450

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 340 AUG - 4 1969
a. COUNTY Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 3 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

Bureau of Vital Stat. 403 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert 340
d. STREET ADDRESS (If rural, give location) 275 north 100 east

3. NAME OF DECEASED (Type or Print) a. (First) Reid b. (Middle) I. c. (Last) Short
4. DATE OF DEATH (Month) (Day) (Year) July 30 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb 7 1918
9. AGE (In years last birthday) 51 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and Ditch Rider
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Thornfield Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME H.F.Short 04 BIRTHPLACE Sneadville Tennesee
14. MOTHER'S MAIDEN NAME Pearl Spears BIRTHPLACE Sneadvile Tennesee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) U.S. Air Force W.W.II 4109
16. SOCIAL SECURITY 519-18 0435
17. INFORMANT'S OWN SIGNATURE X Hugh P. Short ADDRESS 805 E Rupert Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 2-3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASCVD — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1957, to 7-30-69, 19__, that I last saw the deceased alive on _____, 1969, and that death occurred at 1:00 A m., from the causes and on the date stated above.*

23a. SIGNATURE 253 Ben K. Humphrey (Degree or title) MP 1
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 7-3-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-2-69
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho
DATE REC'D BY LOCAL REG. 8-1-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Robert C Walk LICENSE NO. E 294

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 2 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3329
Local Reg. No. 195
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JUL 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 NezPerce
b. CITY OR TOWN Lewiston
LENGTH OF STAY (in this place) 1 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 351
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 0118-25th St

3. NAME OF DECEASED (Type or Print) a. (First) Alfred b. (Middle) E. c. (Last) Johnston

4. DATE OF DEATH (Month) June (Day) 4 (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Jan 4, 1879

9. AGE (In years last birthday) 90 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Marshelltown, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Johnston BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME Emma Barnard BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 3

16. SOCIAL SECURITY NO. 2699

17. INFORMANT'S OWN SIGNATURE X Don Johnston ADDRESS Lenore, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) heart failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) inanition
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 3, 19 69 *to* June 4, 19 69, *that I last saw the deceased alive on* June 4, 19 69, *and that death occurred at* 6:20a *m., from the causes and on the date stated above.*

23a. SIGNATURE X D E Lupe 502 (Degree or title) md
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 6-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE June 7.1969
24c. NAME OF CEMETERY OR CREMATORY Sunnyside Cemetery
24d. LOCATION (City, town, or county) (State) Lenore, Idaho.

DATE REC'D BY LOCAL REG. 7-29-69
REGISTRAR'S SIGNATURE Glenara Walzer
25. EMBALMER Andrew F. Vassar
LICENSE NO. E315.

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3380
Local Reg. No. 185
Reg. Dist. No. 220

Certificate of Death

RECEIVED JUL 16 1969

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF [illegible] 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Reeds Nursing Home 335

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 351
d. STREET ADDRESS (If rural, give location) 1804-6th Ave N

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle)
c. (Last) Raspone

4. DATE OF DEATH (Month) (Day) (Year) July 2, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 4, 1880
9. AGE (In years last birthday) 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Vico Toggis, Italy
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Paul Raspone — BIRTHPLACE Italy
14. MOTHER'S MAIDEN NAME Nancy Quita — BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 — (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 519-03-6537
17. INFORMANT'S OWN SIGNATURE Lucille Forkner — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1937, *to* July 2, 1969, *that I last saw the deceased alive on* 6-28, 1969, *and that death occurred at* 2 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 083 John E Carssonny
23b. ADDRESS 9th and Main Street Lewiston, Ida
23c. DATE SIGNED 7/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 7, 1969
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG. 7-9-69
REGISTRAR'S SIGNATURE Glenara Walzen
25. EMBALMER Andrew F. Vassar
LICENSE NO. E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 24 1969

OCT 22 1982

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to certify the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3381
Local Reg. No. 187
Reg. Dist. No. 230

BIRTH NO. 69-7337

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48 b. COUNTY Whitman 555
c. CITY OR TOWN Colfax
d. STREET ADDRESS (If rural, give location) Route # 2 Box # 131

3. NAME OF DECEASED (Type or Print) a. (First) DANIELLE b. (Middle) LEA c. (Last) FEENAN

4. DATE OF DEATH (Month) July (Day) 4, (Year) 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH July 3, 1969
9. AGE (In years last birthday) 0 IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 20 Min. 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Joseph Craig Feenan BIRTHPLACE Colfax, Wash
14. MOTHER'S MAIDEN NAME Fern Mae Howard BIRTHPLACE Coeur D'Alene, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE J. Craig Feenan ADDRESS Colfax, Wa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Erythroblastosis fetalis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 1969, to July 4, 1969, that I last saw the deceased alive on July 4, 1969, and that death occurred at 5 A m., from the causes and on the date stated above.

23a. SIGNATURE 325 (Degree or title) 1
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial
24b. DATE July 5, 1969
24c. NAME OF CEMETERY OR CREMATORY St. John Cemetery
24d. LOCATION (City, town, or county) (State) St. John, Whitman, Washington

DATE REC'D BY LOCAL REG. 7-9-69
REGISTRAR'S SIGNATURE Glenna Walzen
25. EMBALMER Ray C. Brown
LICENSE NO. QL 219

FIRM NAME: L. L. Bruning Funeral Home
N. 109 Mill St., Colfax, Washington

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3382
Local Reg. No. 186
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston, Idaho. 351
d. STREET ADDRESS (If rural, give location): 705- F.St

3. NAME OF DECEASED (Type or Print)
a. (First): Albert
b. (Middle):
c. (Last): Larson

4. DATE OF DEATH (Month) (Day) (Year): July 5, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb 11, 1886
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cedar Rapids, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: August Larson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Catherine Walker — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 521-30-7916 A
17. INFORMANT'S OWN SIGNATURE: Dorothy A. Miles — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial Infarction	9 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cororary artery thrombosis	9-10 days
DUE TO (c)	Coronary artery Sclerosis	10 ++ years
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov., 1965, *to* 5 July, 1969, *that I last saw the deceased alive on* 5 July, 1969, *and that death occurred at* 1:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 496 B R Stein MD
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 8 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7-8-1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 7-9-69
REGISTRAR'S SIGNATURE: Glenara Wolzen
25. EMBALMER: Andrew F. Vassar
LICENSE NO.: E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

...nformant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3383
Local Reg. No. 189
Reg. Dist. No. 320

Certificate of Death

STATE OF IDAHO

RECEIVED

JUL 16 1969

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NezPerce 35
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION 431 1/2 Preston 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 431 1/2 Preston

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Percy	n/m/n	Henderson	July 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	26 August 1897	72	11	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	own farm	Peck, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
T. Baxter Henderson	Oregon	Grace Springston	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	518-36-1633	X Harold L Henderson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Asystole — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocardial Infarct

DUE TO (c) Arterio Sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Stroke

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4/3/, 19[illegible], *to* 7/7, 19[illegible], *that I last saw the deceased alive on* 7/4, 19[illegible] *and that death occurred at* 11:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	St Johns Way	7/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY ~~OR CREMATORY~~	24d. LOCATION (City, town, or county) (State)
Burial	12 July 1969	Normal Hill	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69	[signature]	L. E. DeBaun	E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

AUG 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 25 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3384
Local Reg. No. 196
Reg. Dist. No. 220

BIRTH NO. 69-7340

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN Lewiston (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (in this place) 30 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
d. STREET ADDRESS (If rural, give location) 1033 Powers

3. NAME OF DECEASED (Type or Print) a. (First) Baby boy b. (Middle) c. (Last) Vazanko

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH July 6, 1969

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 21 Min. 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 02

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Lewiston, Idaho

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Harry Vazanko
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Myrna
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Harry W. Vazanko ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyaline Membrane & Shock

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Premature Labor, &

DUE TO (c) of Placenta.

INTERVAL BETWEEN ONSET AND DEATH
Separate

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/6, 19__, *to* 7/7/69, 19__, *that I last saw the deceased alive on* 7/7, 19__, *and that death occurred at* 3:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE 420 W.J. Pence (Degree or title) MD

23b. ADDRESS Lewiston

23c. DATE SIGNED 7/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE July 9, 1969

24c. NAME OF CEMETERY OR CREMATORY Normal Hill cemetery

24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 7-29-69

REGISTRAR'S SIGNATURE Glenna Walgen

25. EMBALMER V. Vassar

LICENSE NO. E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3385
Local Reg. No. 190
Reg. Dist. No. 220

RECEIVED
JUL 16 1969
Bureau of Vital Sta.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 351
a. COUNTY: NEZ PERCE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
c. LENGTH OF STAY (in this place): 3 mos. 203
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LEWISTON MANOR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: NEZ PERCE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CULDESAC 350
d. STREET ADDRESS (If rural, give location): P. O. BOX - 96

3. NAME OF DECEASED (Type or Print) 312
a. (First): MARTHA
b. (Middle): JANE
c. (Last): LEE

4. DATE OF DEATH (Month) (Day) (Year): 9 JULY 1969

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2
8. DATE OF BIRTH: 31 JULY 1876
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER 01
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): INDIANA
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: MARTIN POICEL — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: LYDIA ? — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518 60 7589
17. INFORMANT'S OWN SIGNATURE: X Bernard E Lee — ADDRESS: Culdesac, Idaho

18. CAUSE OF DEATH 4369
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myopathic Hemiplegia
DUE TO (c) due to CVA

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1968, *to* 9 July, 1969, *that I last saw the deceased alive on* July 8, 1969 *and that death occurred at* 11 A.M. *m.; from the causes and on the date stated above.*

23a. SIGNATURE 020 (Degree or title): [signature]
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 11 Jul '69

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 11 JULY 1969
24c. NAME OF CEMETERY OR CREMATORY: CITY CEMETERY
24d. LOCATION (City, town, or county) (State): CULDESAC, IDAHO

DATE REC'D BY LOCAL REG.: 7-15-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3386
Local Reg. No. 197
Reg. Dist. No. 220

BIRTH NO. 69-4039

RECEIVED JUL 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 35 NezPerce
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 1
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lapwai
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Anthony; b. (Middle) Shane; c. (Last) Spencer

4. DATE OF DEATH: (Month) July (Day) 9 (Year) 1969

5. SEX: male

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: April 8 1969

9. AGE (In years last birthday): 0 IF UNDER 1 YEAR Months 3 Days 1 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Lewiston, Idaho.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Spencer BIRTHPLACE: Winegar, Wis.

14. MOTHER'S MAIDEN NAME: Juanita Hayes BIRTHPLACE: Lapwai, Idaho.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: nohe

17. INFORMANT'S OWN SIGNATURE: Juanita Spencer ADDRESS: Lapwai, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

484 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Interstitial pneumonitis.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) and Tracheobronchitis.
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: DOA.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 290 M.D.

23b. ADDRESS: Box 956, Lewiston, Idaho

23c. DATE SIGNED: 7-24.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 11, 1969

24c. NAME OF CEMETERY OR CREMATORY: Lapwai Tribal Cemetery

24d. LOCATION (City, town, or county) (State): Lapwai, Idaho.

DATE REC'D BY LOCAL REG.: 7-29-69

REGISTRAR'S SIGNATURE: Elnora Walzen

25. EMBALMER: Andrew F. Vassar LICENSE NO. E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3387
Local Reg. No. 198
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (In this place) 7 weeks 202
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) S. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perde
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards 351
d. STREET ADDRESS (If rural, give location) 1915 Grelle

3. NAME OF DECEASED (Type or Print) a. (First) Zelma b. (Middle) c. (Last) Dahl

4. DATE OF DEATH (Month) (Day) (Year) July 12, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Sept. 14, 1918
9. AGE (In years last birthday) 51 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Rosston, Arkansas
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Quinton Taylor BIRTHPLACE Alabama
14. MOTHER'S MAIDEN NAME Eunice Biddle BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 430 26 6589
17. INFORMANT'S OWN SIGNATURE X Carl J Dahl ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — years
DUE TO (c) Diabetes Mellitus — 16 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Generalized Arteriosclerosis — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11, 1968, *to* 7-12, 1969, *that I last saw the deceased alive on* 7-12, 1969, *and that death occurred at* 4:08 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 15, 1969
24c. NAME OF CEMETERY OR CREMATORY Lewis Clark Memorial Gardens Normal Hill cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 7-29-69
REGISTRAR'S SIGNATURE Glenda Dalzen
25. EMBALMER V. Vassar
LICENSE NO. E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Johnson

DUTIES:

AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3388
Local Reg. No. 192
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 301 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1416 13th Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mina	Ethel	Trout	July 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	July 18, 1883	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	at home	Halsey, Oregon	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pleasant T. Brock	Tenn.	Miranda Sippy	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	2 8	519-58-7210	Mrs. Henry C. Hansen	Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Art Disease — 2 yrs.
DUE TO (c) Hypertension — 2 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 1967, 19__, to July 15, 1969, that I last saw the deceased alive on July 14, 1969, and that death occurred at 4:55 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
022 Joseph E Burdett MD	1522-17th St. City	7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	25. EMBALMER	LICENSE NO.
Burial	July 19, 1969	Moscow Cemetery	Moscow Idaho	Donald Ward	E-80

DATE REC'D BY LOCAL REG. 7-24-69
REGISTRAR'S SIGNATURE Glenna Dalzen
FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3389
Local Reg. No. 199
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 35 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Washington 48 COUNTY Wittman 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Uniontown
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Bertilla b. (Middle) c. (Last) Moneymaker
4. DATE OF DEATH (Month) (Day) (Year) July 17 1969
5. SEX female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan 24, 1912
9. AGE (In years last birthday) 57 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Uniontown, Wash
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Heitstuman BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Mary Westhoff BIRTHPLACE Ill.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 539-56-0432
17. INFORMANT'S OWN SIGNATURE X David Moneymaker ADDRESS Uniontown, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 19 69, *to* July 17, 19 69, *that I last saw the deceased alive on* July 17, 19 69, *and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE X [signature] (Degree or title)
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 7-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE July 21, 1969
24c. NAME OF CEMETERY OR CREMATORY Uniontown Catholic Cemetery
24d. LOCATION (City, town, or county) (State) Uniontown, Wash.

DATE REC'D BY LOCAL REG. 7-29-69
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Andrew F. Vassar
LICENSE NO. E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3390
Local Reg. No. 194
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 000
b. CITY OR TOWN: Lewiston
LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 1009 - 20th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HOMER	MARION	CLARK	20 July 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	White 3	11 Nov. 1917	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver 27	Logging/Lumber	Gifford, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Philander H. Clark	Tenn.	Minnie M. Hayes	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES / WW-2 4	518 12 3333	Mrs. Elsie M. Clark	Lewiston, Id.

MEDICAL CERTIFICATION

4272

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardiac arrest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-20-69, 19___ *to* 7-20-69, 19___, *that I last saw the deceased alive on* 7-20-69, 19___, *and that death occurred at* 3:55 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
502 J Stipe MD. 1	Lewiston, Idaho	7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	26 July 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-29-69	Glenard Dalgen	W E Black	E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3391
Local Reg. No. 193
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 101 Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor Nursing Home 3/2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 718 - 7th Street

3. NAME OF DECEASED (Type or Print): a. (First) FANNIE b. (Middle) JESSIE c. (Last) RAGON

4. DATE OF DEATH (Month) (Day) (Year): 20 July 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 27 March 1880
9. AGE (In years last birthday): 89 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Johnson — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Jessie Laughon — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 2 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no record
17. INFORMANT'S OWN SIGNATURE: Horace J. Ragon — ADDRESS: Spokane, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-23, 1968, *to* 7-20, 1969, *that I last saw the deceased alive on* 6-25, 1969, *and that death occurred at* 10:10AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] Duncan M.D.
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 7-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 23 Jul 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 7-24-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

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IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3392
Local Reg. No. 205
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1534 'G' Street

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) V. c. (Last) DOWNING

4. DATE OF DEATH (Month) (Day) (Year) 25 July 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 30 March 1908

9. AGE (In years last birthday) 61 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 22 Owner-Operator

10b. KIND OF BUSINESS OR INDUSTRY Cafe

11. BIRTHPLACE (State or foreign country) Hobart, Oklahome

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Downing | BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Ethel Wallace | BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) no record 0

16. SOCIAL SECURITY NO. no record

17. INFORMANT'S OWN SIGNATURE X Mrs Chas Downing ADDRESS Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1621 Lung Metastatic Bronchial Carcinoma Rt Cerebellum — INTERVAL BETWEEN ONSET AND DEATH 2 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Primary Bronchial Carcinoma rt lung

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Metastases to both Kidneys and left lung
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 7-7-69

19b. MAJOR FINDINGS OF OPERATION Primary adeno Carcinoma rt lower lobe

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-26, 1963, *to* 7-25, 1969, *that I last saw the deceased alive on* 7-25, 1969, *and that death occurred at* 12:25 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Ralph Haas Jr MD

23b. ADDRESS Clarkston Wash

23c. DATE SIGNED 7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 28 July 1969

24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery

24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 8-6-69

REGISTRAR'S SIGNATURE Glenard Dalgas

25. EMBALMER W E Black

LICENSE NO. E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

AUG 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3393
Local Reg. No. 200
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 35 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 16days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 35
d. STREET ADDRESS (If rural, give location): 22-19-9th Ave

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Kermit	R	Miller	July 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	White	Divoiced	July 13, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber 21
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Longmount, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Matt Miller — BIRTHPLACE: Mo
14. MOTHER'S MAIDEN NAME: Caroline Paipe — BIRTHPLACE: Colorado.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 530 1579
17. INFORMANT'S OWN SIGNATURE: Raymond E. Miller — ADDRESS: Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinom. pancreas — INTERVAL BETWEEN ONSET AND DEATH: 3 Mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1947 19__ *to* 7/25/69, 19__, *that I last saw the deceased alive on* 7/24/69, 19__, *and that death occurred at* 12:30 pm *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm E Curson MD	9th and Main Street Lewiston, Idaho 83501	7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-26-69	Normal Hill Cemetery	Lewiston, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-29-69	Elnora Dalzen	Andrew F. Vassar	E515

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3394
Local Reg. No. 1824
Reg. Dist. No. 220

BIRTH NO.

RECEIVED AUG 15 1969

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Bureau (Rural) 302
c. LENGTH OF STAY (in this place): 53 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Wash. 48
b. COUNTY: Asotin 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 734 - 9th Street

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) ALEXANDER c. (Last) WILSON

4. DATE OF DEATH: (Month) 25 July (Day) (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 27 Dec. 1898

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tractor Opr. 17

10b. KIND OF BUSINESS OR INDUSTRY: Logging

11. BIRTHPLACE (State or foreign country): Kendrick, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alexander Wison
BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Mary Burns
BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES 1
(If yes, give war or dates of service): WW2 4

16. SOCIAL SECURITY NO.: 518 01 2292

17. INFORMANT'S OWN SIGNATURE: Mrs James Wilson ADDRESS: Clarkston, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 8 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 3/26/69

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Prostate

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1961, to July, 1969, that I last saw the deceased alive on 7/24, 1969, and that death occurred at 7 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): 462 Russell T. Scott M.D.

23b. ADDRESS: Lewiston Ida

23c. DATE SIGNED: 7/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 28 Jul 1969

24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-1-69

REGISTRAR'S SIGNATURE: Glenna Wolzen

25. EMBALMER: W E Black

LICENSE NO.: E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 15 1969

State File No. 3395
Local Reg. No. 3395
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 310 7-17-69
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nelson Nursing Home 129

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 351
d. STREET ADDRESS (If rural, give location) 1132 Idaho Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Isaac	Menzo	Carter	July 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 5	March 4, 1881	88	4	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Self Employed	Kentucky	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Susberry Carter	unknown	Adelia unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	4379	Mrs Garnet Stellyes	Reubens, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1969, *to* July 27, 1969, *that I last saw the deceased alive on* July 19, 1969, *and that death occurred at* ——— *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] MD	307 J St Lewis WA	8/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 30, 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-6-69	Leonard Walzen	W.E. Black	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

DUTIES:

AUG 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 8 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3396
Local Reg. No. 201
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JUL 31 1969 Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 NezPerce
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 309 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Asotin 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Asotin
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Ellen
b. (Middle)
c. (Last) Ebsen

4. DATE OF DEATH (Month) July (Day) 27 (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct 4, 1914

9. AGE (In years last birthday) 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 01

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Kendrick, Idaho.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Woody
BIRTHPLACE N.C.

14. MOTHER'S MAIDEN NAME Martha W. Baldwin
BIRTHPLACE Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE X Ellen Ebsen
ADDRESS Asotin Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 26, 1969, *to* July 27, 1969, *that I last saw the deceased alive on* July 27, 1969, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature]

23b. ADDRESS 1522 17th St. Lewiston

23c. DATE SIGNED 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE July 30.1969

24c. NAME OF CEMETERY OR CREMATORY AmericanRidge Cemetery

24d. LOCATION (City, town, or county) Juliaetta, Latah Co. (State) Idaho

DATE REC'D BY LOCAL REG. 7-31-69

REGISTRAR'S SIGNATURE Glenard Dalzell

25. EMBALMER Andrew F. Vassar

LICENSE NO. E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 13 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3397
Local Reg. No. 206
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 15 1969 Bureau of

BIRTH NO.

1. PLACE OF DEATH 351

a. COUNTY: Nez Perce 319

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

c. LENGTH OF STAY (in this place): 19 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor Nursing Home 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Nez Perce 351

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

d. STREET ADDRESS (If rural, give location): 502 Bryden Drive

3. NAME OF DECEASED (Type or Print)

a. (First): JEAN

b. (Middle): MAY

c. (Last): DICKERSON

4. DATE OF DEATH (Month) (Day) (Year): 31 July 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 8 August 1886

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Jermyn, Penna.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Erastus Smith — BIRTHPLACE: Penna.

14. MOTHER'S MAIDEN NAME: Elizabeth M. Miller — BIRTHPLACE: Penna.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO 2 — (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 519 07 9474

17. INFORMANT'S OWN SIGNATURE: Jeanette J. Lawrence — ADDRESS: West Covina, Calif

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Cerebral Arteriosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~6~~ *19*69*, to* 7/29*, 19*69 *that I last saw the deceased alive on* 7/29*, 19*69*, and that death occurred at* 7:45 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lemon 114

23b. ADDRESS: St Robins Way

23c. DATE SIGNED: 8 4 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 4 Aug 1969

24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-6-69

REGISTRAR'S SIGNATURE: Glenara Dalzen

25. EMBALMER: W E Black — W E Black

LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3398
Local Reg. No. 16
Reg. Dist. No. 530

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Oneida 360 AUG - 4 1969 184
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad Bureau
c. LENGTH OF STAY (in this place) 84 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Oneida Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Oneida 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad
d. STREET ADDRESS (If rural, give location) 72 West 400 North St.

3. NAME OF DECEASED (Type or Print)
a. (First) THOMAS
b. (Middle) DAVIS
c. (Last) EVANS

4. DATE OF DEATH (Month) (Day) (Year) July 28, 1969

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH May 1, 1885
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate broker 24
10b. KIND OF BUSINESS OR INDUSTRY Real Estate sales
11. BIRTHPLACE (State or foreign country) Malad, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin D. Evans — BIRTHPLACE Wales
14. MOTHER'S MAIDEN NAME Mary Jane Jones — BIRTHPLACE Salt Lake City, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 — (If yes, give war or dates of service) -- 0
16. SOCIAL SECURITY NO. 519-28-4378
17. INFORMANT'S OWN SIGNATURE June E. Ward — ADDRESS Malad, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION 1530

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) abdominal abscess

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) adeno carcinoma ?

DUE TO (c) metastasis - Primary site

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Cecum

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* July 28, 1969, *and that death occurred at* 10:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 315 [signature]
23b. ADDRESS Malad Idaho
23c. DATE SIGNED July 31-1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 31, 1969
24c. NAME OF CEMETERY OR CREMATORY Malad City Cemetery
24d. LOCATION (City, town, or county) Malad (State) Idaho

DATE REC'D BY LOCAL REG. July 31-1969
REGISTRAR'S SIGNATURE Ruth G. Sweeten
25. EMBALMER Rajford G. Benson — LICENSE NO. E-351

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: BENSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 11 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. APR 5 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED 370 AUG 6 1969 Bureau of Vital Statistics 314

State File No. 3399
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: OWYHEE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GRANDVIEW
c. LENGTH OF STAY (In this place): 2 WEEKS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GRANDVIEW, IDAHO 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: ILLINOIS 14 b. COUNTY: WHITESIDE 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): MORRISON
d. STREET ADDRESS (If rural, give location): ROUT #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lloyd	Allen	Oostenyk	July 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married 3	January 11, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	Farm	MORRISON, ILLINOIS	USA.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JACOB OOSTENYK	MORRISON, ILL.	OTENA DYKEMA MISKEGYN	MICHIGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 2	0		* Jean A. Shell	Grandview

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 7963 Natural Causes — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I ~~attended the deceased from~~ investigation only 19 , to , 19 , that I ~~last saw the deceased alive~~ did not see on July 29, 1969, and that death occurred at 10:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Andrew Warfield - Coroner 4 583	Homedale, Idaho	Aug. 4 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 3	7-30-69	Grove Hill Cemetery	Morrison, Illinois

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 4 1969	Andrew Warfield	[signature]	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3400
Local Reg. No. 126
Reg. Dist. No. 330

Certificate of Death

RECEIVED
JUL 8 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 1 Day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 228 14th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): CLIFTON
b. (Middle): LEROY
c. (Last): WILLIAMS

4. DATE OF DEATH (Month) (Day) (Year): July 1, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 25, 1890
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months - Days - IF UNDER 24 HRS.: Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer 21
10b. KIND OF BUSINESS OR INDUSTRY: Masonry
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Owen Williams — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Clara Sutphan — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): -0
16. SOCIAL SECURITY NO.: 519-12-0538 A
17. INFORMANT'S OWN SIGNATURE: Mrs Dorothy Kelly — ADDRESS: Payette, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cerebrovascular Dis. - 6 mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
3rd degree burn left leg. — 2 wks.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1956, *to* July 1, 1969, *that I last saw the deceased alive on* June 30, 1969, *and that death occurred at* 6:35A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. G. Carroll, 082 M.D.
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 7-2-1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-3-1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: 7-7-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3401
Local Reg. No. 129
Reg. Dist. No. 330

BIRTH NO.

RECEIVED JUL 16 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN Payette
c. LENGTH OF STAY (in this place) 8 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION Casa Loma Convalescent Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN Payette
d. STREET ADDRESS (If rural, give location) 538 N 6th St.

3. NAME OF DECEASED (Type or Print) 355
a. (First) ETHEL
b. (Middle) FLORENCE
c. (Last) McKINNON

4. DATE OF DEATH (Month) July (Day) 5, (Year) 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 5, 1889
9. AGE (In years last birthday) 80
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Hall
BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2
(If yes, give war or dates of service) — — 0 —
16. SOCIAL SECURITY NO. 519-60-0032J1
17. INFORMANT'S OWN SIGNATURE Dorothy Smead
ADDRESS Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized atherosclerosis — INTERVAL BETWEEN ONSET AND DEATH yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 56 *to* July 5, 1969 *that I last saw the deceased alive on* June 30 1969 *and that death occurred at* 6:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Thomas E. Walker (Degree or title) M.D.
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-8-1969
24c. NAME OF CEMETERY OR CREMATORY Riverside
24d. LOCATION (City, town, or county) Payette (State) Idaho

DATE REC'D BY LOCAL REG. 7-14-69
REGISTRAR'S SIGNATURE
25. EMBALMER
LICENSE NO. E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 12 1982

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3402
Local Reg. No. 127
Reg. Dist. No. 330

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

380 JUL 9 1969 104

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Payette	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho b. COUNTY: 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette c. LENGTH OF STAY (In this place): 4 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Truck Rt. 1 Mi. S. Payette	d. STREET ADDRESS (If rural, give location): 234 S. 7th

3. NAME OF DECEASED (Type or Print)	a. (First): Cecil	b. (Middle): Edward	c. (Last): West	4. DATE OF DEATH (Month) (Day) (Year): July 5 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: Dec. 12 1910	9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27	10b. KIND OF BUSINESS OR INDUSTRY: Freightlines	11. BIRTHPLACE (State or foreign country): Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1	(If yes, give war or dates of service): WW II 4	16. SOCIAL SECURITY NO.: 524-28-9933	17. INFORMANT'S OWN SIGNATURE: x Mrs Mary E West	ADDRESS: Payette Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*	(a) Myocardial infarction	5 min.
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*	DUE TO (b) Coronary thrombosis	5 min.
	DUE TO (c) arteriosclerotic coronary artery disease	2 yrs.
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 19, 1968, *to* July 5, 1969, *that I last saw the deceased alive on* June 29, 1969, *and that death occurred at* 8:15pm *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 082 E. G. Carroll, M.D.	23b. ADDRESS: Payette, Idaho	23c. DATE SIGNED: 7/7/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: 7-11-69	24c. NAME OF CEMETERY OR CREMATORY: Willamette National Cemetery	24d. LOCATION (City, town, or county) (State): Portland Oregon
DATE REC'D BY LOCAL REG.: 7-8-69	REGISTRAR'S SIGNATURE: [signature]	25. EMBALMER: Donald F Brown	LICENSE NO.: E-408

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Chapel of the Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3403
Local Reg. No. 130
Reg. Dist. No. 330

BIRTH NO.

RECEIVED
JUL 16 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 68 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 401 S. 9th St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 401 S. 9th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ELLIS	LEO	FAIL	July	6,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	July 8, 1899	69	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Carpentering	Geneseo, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Frances Fail	Missouri	Mina May Forney	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	—	511-12-0488	Mrs. Nettie Fail	Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Congestive failure — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1963, 19—, *to* 7-6-, 1969, *that I last saw the deceased alive on* 7-3-69, 19—, *and that death occurred at* 12:20AM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Payette, Idaho	7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	7-11-1969	Graceland Cemetery	Lyons, Rice County, Kansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-69			E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 23 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3404
Local Reg. No. 131
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 2½ Years 103
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): Ash Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE		FLACK	July	7,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	June 1, 1880	89	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trucker 27	Trucking	Wesley, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Abner Joseph Flack	Illinois	Charlotte Ward	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	— —	518-07-4059A 4339	Charlotte Broderson	Payette Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute arteriosclerotic cerebral thrombosis	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Generalized arteriosclerotic cerebral and cardiac ischemia	5 yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Chronic benign prostatic hypertrophy Chronic diseases, arthritis of hands	10 yrs. 5 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 4, 1969, *to* July 7, 1969, *that I last saw the deceased alive on* July 7, 1969, *and that death occurred at* 10:25 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jos. E. Davis 131	M.D.	New Plymouth, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-11-1969	Park View	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-18-69	Gwendolyn Anderson	Keith M. Jensen	E-517

FIRM NAME: SHAFFER*JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 3 1 1990

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 8 1998

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3405
Local Reg. No. 132
Reg. Dist. No. 330

Certificate of Death

RECEIVED
JUL 24 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Payette 380	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho b. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette 150	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convlescent Center 355	d. STREET ADDRESS (If rural, give location): 1017 2nd S.

3. NAME OF DECEASED (Type or Print)	a. (First) Ramona	b. (Middle) Frances	c. (Last) Sesena	4. DATE OF DEATH (Month) (Day) (Year) July 17 1969
5. SEX: Female	6. COLOR OR RACE: Spanish	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow 2	8. DATE OF BIRTH: Nov. 7 1889	9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Calif.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0 (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Mrs. Virgil A. Goff	ADDRESS: Payette, Idaho	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia	3 days
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral thrombosis	6 days
DUE TO (c)	Arteriosclerotic Cerebrovascular Dis.	1 year
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Previous cerebral thrombosis	2 mos.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 7, 1969, *to* July 17, 1969, *that I last saw the deceased alive on* July 16, 1969, *and that death occurred at* 3:30PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. G. Carroll, M.D. 082	23b. ADDRESS: Payette, Idaho	23c. DATE SIGNED: 7/21/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 7-21-69	24c. NAME OF CEMETERY OR CREMATORY: Rosedale Memoral Gardens
24d. LOCATION (City, town, or county) (State): Payette Idaho		
DATE REC'D BY LOCAL REG.: 7-23-69	REGISTRAR'S SIGNATURE: Annabel Anderson	25. EMBALMER: Donald F Brown — LICENSE NO. E-408

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Chapel of the Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 9 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 24 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3406
Local Reg. No. 133
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 25 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1134 7 Ave OOO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 1134 7th Ave

3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) S. c. (Last) Wayne

4. DATE OF DEATH (Month) (Day) (Year) July 19 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divoreed 4

8. DATE OF BIRTH May 28 1882

9. AGE (In years last birthday) 87
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Wayne BIRTHPLACE Wisconsin

14. MOTHER'S MAIDEN NAME Wealtha Powell BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) 2

16. SOCIAL SECURITY NO. 555-30-1366

17. INFORMANT'S OWN SIGNATURE x Wanda M Wells ADDRESS Payette, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic heart disease — yrs

DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4189

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 68 *19____, to* 7-19- *19*69*, that I last saw the deceased alive on* 7-3-69 *19____, and that death occurred at* 8:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE 574 (Degree or title)

23b. ADDRESS 16 S. 9th. Payette, Ida.

23c. DATE SIGNED 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-22-69

24c. NAME OF CEMETERY OR CREMATORY Riverside

24d. LOCATION (City, town, or county) Payette (State) Idaho

DATE REC'D BY LOCAL REG. 7-23-69

REGISTRAR'S SIGNATURE

25. EMBALMER Donald F Brown

LICENSE NO. E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3407
Local Reg. No. 134
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Payette 380	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Idaho b. COUNTY Custer 190
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette c. LENGTH OF STAY (in this place) 000	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Challis
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montclair Motel S. 8th St. 000	d. STREET ADDRESS (If rural, give location) P. O. Box 342

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harold	Harvey	Anderson	July	27	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 15, 1894	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trucker of Produce 27	Trucking	Furley, Kansas	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James William Anderson	Kansas	Martha Osman	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	No 0	557-22-7934	Ada A Anderson	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Exsanguination	1 hour
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Ruptured aortic aneurysm	1 hour
DUE TO (c)	Arteriosclerotic Cardiovascular Disease	1 year
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 27, 1969, *to* July 27, 1969, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. G. Arnold, M.D. 082	Payette Idaho	7/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-2-69	Sunset Memorial Park	Twin Falls, Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-30-69	Annabel Anderson	Milford O Drages	E318

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Chapel of The Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3408
Local Reg. No. 135
Reg. Dist. No. 330

Certificate of Death

RECEIVED AUG 12 1969

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette (Rural)
c. LENGTH OF STAY (in this place): Minutes 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Snake River North of Payette 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): Route # 1 Box 299

3. NAME OF DECEASED (Type or Print)
a. (First): RUDY
b. (Middle): EARL
c. (Last): ORTEGA

4. DATE OF DEATH (Month) July (Day) 28, (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: May 19, 1950
9. AGE (In years last birthday): 19 — IF UNDER 1 YEAR: Months – Days – IF UNDER 24 HRS.: Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gen. Farm Labor 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): LaGarita, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Laddie Ortega — BIRTHPLACE: Colorado
14. MOTHER'S MAIDEN NAME: Mary Espinosa — BIRTHPLACE: Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): Viet Nam 7
16. SOCIAL SECURITY NO.: 519-54-6562
17. INFORMANT'S OWN SIGNATURE — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

9109

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): River 18
21c. (CITY, TOWN, OR TOWNSHIP): Payette 13 — (COUNTY) Payette 380 — (STATE) Idaho

21d. TIME OF INJURY (Month) July (Day) 28, (Year) 1969 — (Hour) Approx 2:00 A m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Drowned in Snake River near Boat Docks

22. *I hereby certify that I* ~~[illegible]~~ Investigated ~~[illegible]~~ Approx. *deceased* ~~[illegible]~~, *and that death occurred at* 2:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Hardy H Parkson 583 — (Degree or title): Coroner 4
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 8/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 9/2/1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county): Payette — (State): Idaho

DATE REC'D BY LOCAL REG.: 8-8-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 1 5 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 0 8 2012

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3409
Local Reg. No. 1
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Power — 390 — JUL 16 1969 — 326 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls — LENGTH OF STAY (in this place): 26 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	FRANKLIN	WEBB	July 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Never married	Dec. 10, 1884	84	6	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm, Ship yards
11. BIRTHPLACE (State or foreign country): Rockland, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin Webb — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Elizabeth Fife — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 516-09-1732
17. INFORMANT'S OWN SIGNATURE: Ernest Webb — ADDRESS: Am. Falls, Idaho

4409

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Debility & Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 5 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Osteoporesis (metastatic Ca Prostate. — 3 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 3, 1953, *to* July 9, 1969, *that I last saw the deceased alive on* July 9, 1969, *and that death occurred at* 12: Noon *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 11 Jul. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-11-69
24c. NAME OF CEMETERY OR CREMATORY: Valley View Cemetery
24d. LOCATION (City, town, or county) (State): Rockland, Idaho

DATE REC'D BY LOCAL REG.: 7-15-69
REGISTRAR'S SIGNATURE: Irene Duey
25. EMBALMER: H. L. Davis
LICENSE NO.: e-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3410
Local Reg. No. 2
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED
JUL 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 106
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital/37

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EMMA	LENORE	BATTERTON	July 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Married 3	Aug. 9, 1908	60	11	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Raft River, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel Abbott	Unknown	Emma Mitchell	Twin Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Hany Batterton	American Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive CVa with coma — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriolarsclerosis — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Parkinsonian Syndrome
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	None	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1968, *to* July 17, 1969, *that I last saw the deceased alive on* July 16, 1969, *and that death occurred at* 1:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. L. Harris 203 M D	American Falls, Idaho	22 Jul. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial		Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 24, 1969	Irene Deeg	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 30 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3411
Local Reg. No. 151
Reg. Dist. No. 140

RECEIVED
400 JUL 15 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA East Shoshone Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Marvin 138
b. (Middle): Howard
c. (Last): Hopkins

4. DATE OF DEATH (Month) July (Day) 1 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 23, 1910
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Supt. 07
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): Palouse, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lyle Hopkins — BIRTHPLACE: Unkown
14. MOTHER'S MAIDEN NAME: Edith Hites — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 539-01-3654
17. INFORMANT'S OWN SIGNATURE: X Mark A. Hopkins — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thromosis — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1969, *to* July 1, 1969, *that I last saw the deceased alive on* July 1, 69, 19__, *and that death occurred at* 10:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 672 William N Dix M.D.
23b. ADDRESS: Wallace
23c. DATE SIGNED: 8 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-5-69
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: July 9, 1969
REGISTRAR'S SIGNATURE: Dale Cornell
25. EMBALMER: Derrell J. Juelfs
LICENSE NO.: E-518

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3412
Local Reg. No. 152
Reg. Dist. No. 140

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 400
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (If in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Edward
b. (Middle): William
c. (Last): Dwyer

4. DATE OF DEATH (Month) (Day) (Year): July 5 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: Oct, 18, 1909
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07
10b. KIND OF BUSINESS OR INDUSTRY: Mines
11. BIRTHPLACE (State or foreign country): Spokane, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William P. Dwyer — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Katherine F. Ryan — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1 — (If yes, give war or dates of service): World War II 4
16. SOCIAL SECURITY NO.: 566-12-7350
17. INFORMANT'S OWN SIGNATURE: Robert P. Dwyer — ADDRESS: 160 King St Wallace Ida

18. CAUSE OF DEATH 880X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2da

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): skull fracture — 2da.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Wallace Corner - 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Wallace 1 Shoshone 400 Idaho.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 3 69 noon m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: fell down steps.

22. *I hereby certify that I attended the deceased from* 7/3/69, 19__, *to* 7/5/69, 19__, *that I last saw the deceased alive on* 7/5/69, 19__, *and that death occurred at* 8:28 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 435 Kurt J Reulli md. 1
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 7/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: July 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: July 9, 1969
REGISTRAR'S SIGNATURE: Dale Cornell
25. EMBALMER: Derrell J. Juelfs — LICENSE NO.: E-518

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3413
Local Reg. No. 157
Reg. Dist. No. 170

Certificate of Death

RECEIVED

STATE OF IDAHO

JUL 25 1969

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN Clarkia
c. LENGTH OF STAY IN THIS PLACE few hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 Rightaway 5 mi. S.E. Bonneville Power

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 377
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 404 So. Polk

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Clifford	Orvil	Dillman		July	8	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	married 3	Sept. 22, 1939	29				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer OC
10b. KIND OF BUSINESS OR INDUSTRY McGregor Triangle
11. BIRTHPLACE (State or foreign country) Orofino, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Orville H. Dillman — BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Edith Carson — BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1957-1964 8
16. SOCIAL SECURITY NO. 519-42-3967
17. INFORMANT'S OWN SIGNATURE × Mrs. Clifford Dillman ADDRESS Moscow

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fracture — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Woods - Clarkia
21c. (CITY, TOWN, OR TOWNSHIP) Clarkia (COUNTY) 400 Shoshone (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-8-69 7½ a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Struck by a log

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 7:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
428 S.R. Rapp M.D.	St. Maries, Idaho	7-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 11, 1969	Pinecrest Cemetery	Deary Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-23-69	Hale Harnell	Gerald Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3414
Local Reg. No. 55
Reg. Dist. No. 142

RECEIVED
401 AUG 7 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY SHoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
d. STREET ADDRESS (If rural, give location) 516 California Street

3. NAME OF DECEASED (Type or Print) 141
a. (First) EDITH
b. (Middle) A.
c. (Last) LAMBERT

4. DATE OF DEATH (Month) (Day) (Year) July 8, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Jan. 18, 1898
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Jose — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Edith — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) --- 0
16. SOCIAL SECURITY NO. 518-24-0323
17. INFORMANT'S OWN SIGNATURE X Roy L. Lambert — ADDRESS Pinehurst, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 20 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart + Brain Disease — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Kellogg (COUNTY) Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1948, *to* 8 July, 1969, *that I last saw the deceased alive on* 18 Jun, 1969, *and that death occurred at* 11:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE Glen M. Whitlow 539 (Degree or title) MD
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 12 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 11, 1969
24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
24d. LOCATION (City, town, or county) Kellogg, Idaho (State)

DATE REC'D BY LOCAL REG. 7-28-69
REGISTRAR'S SIGNATURE Joe [illegible]
25. EMBALMER Dean H. Petersen
LICENSE NO. E-534

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME Cornell's Maisel Fun'l Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3415
Local Reg. No. 158
Reg. Dist. No. 140

Certificate of Death

BIRTH NO. 69-6293

RECEIVED JUL 25 1969 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH 402
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA - Dr. Peterson's Office 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elizabeth Park
d. STREET ADDRESS (If rural, give location): General Delivery - Kellogg, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): Brenda
b. (Middle): Kay
c. (Last): Mitchell

4. DATE OF DEATH (Month) (Day) (Year): July 11 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Child 1
8. DATE OF BIRTH: June 14, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 27; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (State or foreign country): Kellogg, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Mitchell
BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Sybil Siegrist
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): -----0
16. SOCIAL SECURITY NO.: -----
17. INFORMANT'S OWN SIGNATURE: Mrs Sybil Mitchell
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden Death Syndrome (SDS) of Infancy Few minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-25, 1969, *to* 7-11, 1969, *that I last saw the deceased alive on* 7-11, 1969, *and that death occurred at* about 11:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 414 A. M. Peterson, M.D.
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 7-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: July 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Smith Crematory
24d. LOCATION (City, town, or county) (State): Spokane WAshington

DATE REC'D BY LOCAL REG.: 7-23-69
REGISTRAR'S SIGNATURE: Dale L Cornell
25. EMBALMER: Derrell J. Juelfs
LICENSE NO.: E-518

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3416
Local Reg. No. 159
Reg. Dist. No. 140

RECEIVED JUL 25 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone County Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Alfred	G.	Maki	July	12	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	August 5, 1911	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Construction	Republic, Michigan	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Isaac Maki	Hilma Pietala

BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	518-01-9958	X Elmo S. Maki	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Mandible - Metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

1701

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-17, 1969, *to* 7-12, 1969, *that I last saw the deceased alive on* 7-12, 1969, *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
414 G. M. Peterson, M.D.	Wallace, Idaho	7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 15, 1969	Mullan Cemetery	Mullan Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-23-69	Wade Cornell	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
401 JUL 25 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3417
Local Reg. No. 51
Reg. Dist. No. 143

BIRTH NO. 113

1. PLACE OF DEATH
a. COUNTY Shoshone
b. CITY OR TOWN Kellogg
LENGTH OF STAY (in this place) 13 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 310 West Brown Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 401
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kellogg
d. STREET ADDRESS (If rural, give location) 310 West Brown Street

3. NAME OF DECEASED (Type or Print) a. (First) RONALD b. (Middle) DENNIS c. (Last) HATHAWAY

4. DATE OF DEATH (Month) (Day) (Year) July 16, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH Mar. 18, 1947
9. AGE (In years last birthday) 22
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never employed 23
10b. KIND OF BUSINESS OR INDUSTRY ---
11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wylie A. Hathaway BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Olive Johansen BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 518-60-4213
17. INFORMANT'S OWN SIGNATURE X Mrs Wylie Hathaway ADDRESS Kellogg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular failure secondary to Congenital Heart Disease (Tetralogy of Fallot) — INTERVAL BETWEEN ONSET AND DEATH Since birth

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-16, 1969, to 7-16, 1969, that I last saw the deceased alive on 7-16, 1969, and that death occurred at about 2:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 414 G. M. Peterson, M.D.
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-19-69
24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
24d. LOCATION (City, town, or county) (State) Kellogg, Idaho

DATE REC'D BY LOCAL REG. 7-23-69
REGISTRAR'S SIGNATURE Joe Devine
25. EMBALMER Alan H. Peterson
LICENSE NO. E-534
FIRM NAME Cornell's Maisel Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3418
Local Reg. No. 156
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH 400
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA East Shoshone Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Andrew
b. (Middle): 138
c. (Last): Tesky

4. DATE OF DEATH: (Month) July (Day) 16, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 7, 1906

9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Mill

11. BIRTHPLACE (State or foreign country): Hazen, North Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Tesky
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Katharina Weisser
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): 8

16. SOCIAL SECURITY NO.: 501-07-3772

17. INFORMANT'S OWN SIGNATURE: Mrs Martha Tesky
ADDRESS:

18. CAUSE OF DEATH 4123
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-15, 1969, *to* 7-16, 1969 *that I last saw the deceased alive on* 7-15, 1969, *and that death occurred at* 7:50 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 21, 1969

24c. NAME OF CEMETERY OR CREMATORY: Shoshone Memorial Gardens

24d. LOCATION (City, town, or county) (State): Pinehurst, Idaho

DATE REC'D BY LOCAL REG.: 7-23-69

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Derrell J. Juelfs

LICENSE NO.: E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUN 3 0 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 2 5 1976

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3419
Local Reg. No. 154
Reg. Dist. No. 140

BIRTH NO.

RECEIVED
JUL 24 1969
Bureau of Vital Statistics
STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN: Silverton
c. LENGTH OF STAY (in this place): 800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shoshone County Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): 214 Cedar Street

3. NAME OF DECEASED (Type or Print)
a. (First): Hermia
b. (Middle): Edwards
c. (Last): Clark

4. DATE OF DEATH: July 18, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: October 6, 1884
9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Clerk 24
10b. KIND OF BUSINESS OR INDUSTRY: Retail Store
11. BIRTHPLACE (State or foreign country): Cambria, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Edwards
BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Hermia Thomas
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 474-22-8985
17. INFORMANT'S OWN SIGNATURE: X Hermia C. Crosby
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cachexia
INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized atherosclerosis
INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-24-64, 19___, *to* 7-18-69, 19___, *that I last saw the deceased alive on* 7-18-69, 19___, *and that death occurred at* 8:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]
23b. ADDRESS: Wallace Idaho
23c. DATE SIGNED: 7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Cambria Cemetery
24d. LOCATION (City, town, or county) (State): Cambria Wisconsin

DATE REC'D BY LOCAL REG.: 7-22-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Dale L. Cornell
LICENSE NO.: E-406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

AUG 27 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3420
Local Reg. No. 155
Reg. Dist. No. 140

RECEIVED
Bureau of Vital Statistics
JUL 24 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (In this place) 800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) 623½ Cedar Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ivy	Pearl	Comini	July 19 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	November 27, 1905	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Room Clerk 06	Hotel	Wolverine, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Aaron Eva	Unknown	Beatrice Cavill	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	519-26-8309	X Ivy M Comini	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1469 Cachexia — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Squamous CA Oral Pharynx — 10 mo.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-5-60, 19__, *to* 7-19-69, 19__, *that I last saw the deceased alive on* 7-19-69, 19__, *and that death occurred at* 7:40a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Box 200 Wallace, Idaho	7-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 22, 1969	Greenwood Cemetery	Kellogg Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-22-69	[signature]	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3421
Local Reg. No. 53
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Shoshone 401 — AUG 7 1969 — Bureau of Vital Statistics — 136
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 36 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — a. STATE: Idaho — b. COUNTY: Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): McConnell Hotel

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARY	AITA	BOYD	July 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	July 17, 1908	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook & waitress 701
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: William Pinson — BIRTHPLACE: W. Virginia
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-03-8233
17. INFORMANT'S OWN SIGNATURE: x Mrs June C Mastin — ADDRESS: Spokane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4109

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-20, 1969, *to* 7-20, 1969, *that I last saw the deceased alive on* 7-20, 1969, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. C. M. Peterson, M.D.	Wallace, Idaho	7-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 23, 1969	Greenwood Cemetery	Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 7-29-69
REGISTRAR'S SIGNATURE: J. A. Justine
25. EMBALMER: Alan H. Peterson
LICENSE NO.: E-534
FIRM NAME: Cornell's Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3422
Local Reg. No. 54
Reg. Dist. No. 142

RECEIVED AUG 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North of Prichard 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 721 South Division

3. NAME OF DECEASED (Type or Print): a. (First) ROBERT b. (Middle) DANIEL c. (Last) SKEMAN

4. DATE OF DEATH: (Month) July (Day) 20, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: March 12, 1906

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert William Skeman
BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Mary Ann McCutcheon
BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): --- 0

16. SOCIAL SECURITY NO.: 518-01-7717

17. INFORMANT'S OWN SIGNATURE: Mrs. Robert Skeman
ADDRESS: Kellogg

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Thrombosis
INTERVAL BETWEEN ONSET AND DEATH: 2 hrs 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-20 1969 *to* 7-20 1969, *that I last saw the deceased alive on* 7-20 1969, *and that death occurred at about* 7:15 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H4 G. M. Peterson, M.D.
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 7-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 7/24/69
24c. NAME OF CEMETERY OR CREMATORY: Smith & Co.
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 7-29-69
REGISTRAR'S SIGNATURE:
25. EMBALMER: Russell Nikel
LICENSE NO.: E-520

FIRM NAME: Cornell's Maisel Fun'l. Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3423
Local Reg. No. 52
Reg. Dist. No. 142

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Shoshone — 401 AUG 7 1969 — 100
b. CITY OR TOWN: Kellogg — LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 309 Maple 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg — 401
d. STREET ADDRESS (If rural, give location): 309 Maple

3. NAME OF DECEASED (Type or Print): a. (First) MATILDA — b. (Middle) — c. (Last) ALESKO

4. DATE OF DEATH (Month) (Day) (Year): July 24, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Dec. 23, 1884

9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Yugoslavia

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Lawrence Lika — BIRTHPLACE: Yugoslavia

14. MOTHER'S MAIDEN NAME: Lucille — BIRTHPLACE: Yugoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 534-38-6305

17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Portland, Ore.

2841

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1968, *to* July 24, 1969, *that I last saw the deceased alive on* July 17, 1969, *and that death occurred at* 9:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 30 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 28
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 8/1/69
REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature]
LICENSE NO.: E-520

FIRM NAME: Cornell's Maidel Fun'l Chap.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3424
Local Reg. No. 161
Reg. Dist. No. 140

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
AUG 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 400
a. COUNTY Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone County Nursin Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn 400
d. STREET ADDRESS (If rural, give location) Mullan Ave.

3. NAME OF DECEASED (Type or Print) 344
a. (First) Elizabeth
b. (Middle)
c. (Last) Pannebaker

4. DATE OF DEATH (Month) (Day) (Year) July 24, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 8, 1914
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Osburn, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Cassius Patterson — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary Allen — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) --0--
16. SOCIAL SECURITY NO. 518-30-5934
17. INFORMANT'S OWN SIGNATURE Ralph Pannebaker — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of Breast c̄ Generalized

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2½ years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Kellogg (COUNTY) Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 July, 1967, *to* 24 July, 1969, *that I last saw the deceased alive on* 30 June, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 539 Glen M. Whitford (Degree or title) MD
23b. ADDRESS Kellogg, Idaho
23c. DATE SIGNED 11 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 26, 1969
24c. NAME OF CEMETERY OR CREMATORY Osburn Cemetery
24d. LOCATION (City, town, or county) (State) Osburn, Idaho

DATE REC'D BY LOCAL REG. 8-12-69
REGISTRAR'S SIGNATURE Dale Cornell
25. EMBALMER Derrell J. Juelfs
LICENSE NO. E-518

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 12 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 17 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 08 1991

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3425
Local Reg. No. 58
Reg. Dist. No. 142

RECEIVED AUG 14 1969 Bureau of V.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 400
a. COUNTY Shoshone 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
c. LENGTH OF STAY (in this place) 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 725 "A" Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
d. STREET ADDRESS (If rural, give location) 725 "A" Street

3. NAME OF DECEASED (Type or Print)
a. (First) L.
b. (Middle) RAYMOND
c. (Last) NELSON

4. DATE OF DEATH (Month) (Day) (Year) July 27, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH June 1, 1914
9. AGE (In years last birthday) 55 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leachman 07
10b. KIND OF BUSINESS OR INDUSTRY Zinc plant
11. BIRTHPLACE (State or foreign country) Dearing, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Nelson BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Oda Thomas BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) --- 0
16. SOCIAL SECURITY NO. 514-05-0024
17. INFORMANT'S OWN SIGNATURE X Walter I. Nelson ADDRESS Pinehurst, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 6 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-27, 1969, *to* 7-27, 1969, *that I last saw the deceased alive on* 7-27, 1969, *and that death occurred at* about 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 414 G. M. Peterson, M.D.
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 8-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify) cremation
24b. DATE 31 July 1969
24c. NAME OF CEMETERY OR CREMATORY Smith & Co.
24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. 8-5-69
REGISTRAR'S SIGNATURE Joe [illegible]
25. EMBALMER Russell D. Mikel
LICENSE NO. E-520

FIRM NAME: Cornell's Maisel Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 6 1976

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3426
Local Reg. No. 57
Reg. Dist. No. 142

RECEIVED Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 400
a. COUNTY Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place) 300 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone Co. Infirmary 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) Box 178

3. NAME OF DECEASED (Type or Print)
a. (First) ANN
b. (Middle) A.
c. (Last) McDONALD

4. DATE OF DEATH (Month) (Day) (Year) July 28, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Oct. 2, 1910
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Fayetteville, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Lackey — BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Elnora Brooks — BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) --- 0
16. SOCIAL SECURITY NO. 444-05-7749
17. INFORMANT'S OWN SIGNATURE X A. J. McDonald — ADDRESS Kellogg

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular failure secondary — INTERVAL BETWEEN ONSET AND DEATH 10-3-66 to 7-28-69

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) arteriosclerotic heart disease
DUE TO (c) Diabetes Mellitus, Cardiomegaly

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* marked. Hepatomegaly marked

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-3-, 1966, *to* 7-28, 1969, *that I last saw the deceased alive on* 7-28, 1969, *and that death occurred at* 6:40 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 414 A. M. Peterson M.D.
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 31 July 69
24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
24d. LOCATION (City, town, or county) (State) Kellogg, Idaho

DATE REC'D BY LOCAL REG. 8/6/69
REGISTRAR'S SIGNATURE Joe Simms
25. EMBALMER Russell D. Mikel
LICENSE NO. E-520

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Maisel Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 5 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED
AUG 14 1969
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3427
Local Reg. No. 22
Reg. Dist. No. 1-2

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rose Lake 280
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ERNEST	C.	SWEATTE	July 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married 3	June 13, 1915	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Mining	Sagle, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alexander Sweatte	Nebraska	Iva May Washburn	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No / ---	518-01-3706	Pearl Sweatte	Rose Lake, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute coronary thrombosis	few minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertensive heart disease with Angina Pectoris	? 2 years
DUE TO (c)	Chronic glomerulonephritis	? 1 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 28 August, 1956, *to* 30 July, 1969, *that I last saw the deceased alive on* 26 July, 1969, *and that death occurred at* 1 14 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert W. Cordwell, MD	Kellogg, Idaho	7 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	Aug. 2, 1969	Smith and Co.	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/8/69	Joe Larose	Russell D. Maisel	E-520

FIRM NAME: Cornell's Maisel Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 30 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3428
Local Reg. No. 1
Reg. Dist. No. 620

RECEIVED AUG - 5 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 410 Teton
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) near Driggs
c. LENGTH OF STAY (in this place) 660
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2 mi No of Driggs on Highway 320

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Victor
d. STREET ADDRESS (If rural, give location) none given

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Paul	Ralph	Hastings	July 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	never married	Dec 20, 1929	39				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 06	- -	Loma Linda, California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lucas Hastings	Missouri	May Jones	Victor, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO 8169	518-42-8745	X Mary J. Hastings	Victor, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive hemorrhage - cerebrum

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) skull fracture from auto accident

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: immediate

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident 1	state highway 06	2 miles north of Driggs, Teton Co., Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
July 22, 1969 m.		single auto accident -throwing patient out

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 11:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. T. Greene 583	Coroner 4	Driggs, Idaho	July 30, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 26, 1969	Victor Cemetery	Victor, Teton Co, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-2-69	Ella Driggs	Robert Bean	E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3429
Local Reg. No. 2
Reg. Dist. No. 620

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Teton — 4/0 AUG 8 1969 — Bureau of Vital Statistics — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs — c. LENGTH OF STAY (in this place): 8 wks — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Teton 470 — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs — d. STREET ADDRESS (If rural, give location): none given

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	KONSTANTIN	KAROL	ROGACHEVSKY	July 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	Widowed 2	Apr 22, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor 01	- - - - - -	Bialystok, Russia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Uruaf Rogachevsky	Russia	~~Unknown~~	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	- - 0	518-09-6003	X Alexandra R. Gordon	Driggs, Idaho

1538

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Ca of Colon — 3-6 mth

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	tumor at Splenic flexure	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1961, *to* July 22, 1969, *that I last saw the deceased alive on* July 22, 1969, *and that death occurred at* 1:15a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Driggs Idaho	8-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jul 25, 1969	Driggs Cemetery	Driggs Teton Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-6-69	Ella Driggs	Robert A. Bean	E-456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robert Bean Funeral Home

AUG 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3430
Local Reg. No. 3
Reg. Dist. No. 620

BIRTH NO.

RECEIVED AUG 19 1969 BUREAU OF VITAL STATISTICS

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (in this place): 2wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tetonia
d. STREET ADDRESS (If rural, give location): 5 miles no of Driggs

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) THOMAS c. (Last) BEARD

4. DATE OF DEATH (Month) (Day) (Year): July 28, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Nov 3, 1889

9. AGE (In years last birthday): 79 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ranching 04

10b. KIND OF BUSINESS OR INDUSTRY: Ranching

11. BIRTHPLACE (State or foreign country): Coalville, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Thomas Beard, Sr. BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Mary Goodworth BIRTHPLACE: Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 519-12-2263

17. INFORMANT'S OWN SIGNATURE: X Rachel E. Beard ADDRESS: Tetonia, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 18 mo

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) ASHD — 5 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1961, *to* July 28, 1969, *that I last saw the deceased alive on* July 28, 1969, *and that death occurred at* 7:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K Heard MD **23b. ADDRESS**: Driggs Idaho **23c. DATE SIGNED**: 8-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial **24b. DATE**: July 31, 1969 **24c. NAME OF CEMETERY OR CREMATORY**: Cache-Clawson Cemetery **24d. LOCATION** (City, town, or county) (State): Tetonia, Teton, Co., Idaho

DATE REC'D BY LOCAL REG.: 8-16-69 **REGISTRAR'S SIGNATURE**: Ella Gregg **25. EMBALMER**: Robert Bean **LICENSE NO.**: E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3431
Local Reg. No. D-326
Reg. Dist. No. 460

RECEIVED JUL 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly, Idaho
c. LENGTH OF STAY (in this place) 2 years 102
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. View Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Oneida 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad City SPOUSE: J.Edward Gibbs
d. STREET ADDRESS (If rural, give location) 595 Bannock St.

3. NAME OF DECEASED (Type or Print) 297
a. (First) MARY LUCINDA
b. (Middle) HOSKINS
c. (Last) GIBBS

4. DATE OF DEATH (Month) July (Day) 1 (Year) 1969

5. SEX Fe.

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Aug. 22, 1878

9. AGE (In years last birthday) 90
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY --

11. BIRTHPLACE (State or foreign country) Portage, Box Elder, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Oliver C. Hoskins
BIRTHPLACE Georgetown, Ill.

14. MOTHER'S MAIDEN NAME Ellen Jones - Llanlyther,
BIRTHPLACE Glammorganshire, So. Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 529-30-3456

17. INFORMANT'S OWN SIGNATURE Eleanor G. Wright
ADDRESS Hyrum, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Generalized arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-1 *, 19*69*, to* 7-1 *, 19*69*, that I last saw the deceased alive on* 7-1 *, 19*69*, and that death occurred at* 6:40p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 092 Leland H. Clark (Degree or title) M.D
23b. ADDRESS 632 Main Ave N., Twin Falls
23c. DATE SIGNED 7/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 5, 1969
24c. NAME OF CEMETERY OR CREMATORY Portage City Cemetery
24d. LOCATION (City, town, or county) Portage, Box Elder, Utah (State)

DATE REC'D BY LOCAL REG. 7/9/69
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Rulford G. Benson
LICENSE NO. E-351

FIRM NAME: BENSON FUNERAL HOME, Malad, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3432
Local Reg. No. D-230
Reg. Dist. No. 460

BIRTH NO. JUL 1 5 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 420 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 40 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) R.F.D. # 1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 420
d. STREET ADDRESS (If rural, give location) R.F.D. # 1

3. NAME OF DECEASED (Type or Print)
a. (First) MARY
b. (Middle)
c. (Last) SAULIE

4. DATE OF DEATH (Month) (Day) (Year) July 1, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH De;c. 2, 1900
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Dickinson, North Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Taraba — BIRTHPLACE Czechoslovokia
14. MOTHER'S MAIDEN NAME No Record — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 518-68-5187
17. INFORMANT'S OWN SIGNATURE Val Saulie — ADDRESS RFD # 1 Buhl, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 hr.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Auricular fibrillation, Extra-Systoles + Arteriosclerotic Heart Disease. 5-10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Varicose Veins in legs 15-20 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1964, 19__, *to* July 1, 1969, *that I last saw the deceased alive on* 6-27, 1969, *and that death occurred at* 4:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Vern H Anderson, MD (Degree or title) 011
23b. ADDRESS Buhl, Ida
23c. DATE SIGNED 7-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/5/69
24c. NAME OF CEMETERY OR CREMATORY Buhl
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. July 11, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER George Farmer
LICENSE NO. E-480

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

State File No. 3433
Local Reg. No. D-228
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 112
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Twin Falls
LENGTH OF STAY (In this place) 12 yrs.
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Hiway 74 1½ mi. South of South Park 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Twin Falls 420
d. STREET ADDRESS (If rural, give location) Hiway 74 1½ mi. South of South Park

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	HARRISON	WINTER	July 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed 2	Jan. 3, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	City Water Dept.	Harrisonville, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John William Winter	Illinois	Laura Etta Hiler	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	0	519-12-2066	R. A. Winter	Klamath Falls, Oregon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac arrhythmia — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did not attend deceased *, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lloyd D. Edwards Twin Falls Co. Coroner 4	Twin Falls, Idaho 83301	7-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 9, 1969	Twin Falls Cemetery	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1969	Marva D. Marsh	Atchison Boyd	E-490

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3434
Local Reg. No. D-227
Reg. Dist. No. 460

BIRTH NO.

JUL 15 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF (in this place) 17 yrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 421
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 720 Main Avenue North 000	d. STREET ADDRESS (If rural, give location) 720 Main Avenue North

3. NAME OF DECEASED (Type or Print) a. (First) LOUIS	b. (Middle) SEVERN	c. (Last) SJURSON	4. DATE OF DEATH (Month) (Day) (Year) July 5, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Feb. 21, 1889	9. AGE (In years last birthday) 80 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24	10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (State or foreign country) Newman's Grove, Nebraska	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matheas Knute Sjurson	BIRTHPLACE Norway	14. MOTHER'S MAIDEN NAME Anna Margrete Larson	BIRTHPLACE Norway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 518-22-7187	17. INFORMANT'S OWN SIGNATURE Jacen M. Sjurson	ADDRESS Twin Falls, Idaho	

18. CAUSE OF DEATH 2509

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetic

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DID NOT ATTEND DECEASED *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Floyce O. Edwards 583	Twin Falls (Degree or title) County Coroner 4	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 7-9-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1	24b. DATE July 10, 1969	24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301
DATE REC'D BY LOCAL REG. July 10, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	EMBALMER William J. Boyd	LICENSE NO. E-490

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

State File No. 3435
Local Reg. No. D-240
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH 421 a. COUNTY Twin Falls	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 83316 — Length of STAY (In this place) 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 421 Filer Rural 83328
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harrals Nursing Home 205	d. STREET ADDRESS (If rural, give location) Route # 3

3. NAME OF DECEASED (Type or Print) a. (First) IDA	b. (Middle) F.	c. (Last) ABEL	4. DATE OF DEATH (Month) (Day) (Year) July 8, 1969		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH Sept. 17, 1892	9. AGE (In years last birthday) 76	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Homemaking	11. BIRTHPLACE (State or foreign country) Arkansas	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME J. W. Cooper	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Mollie	BIRTHPLACE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) ---- 0	16. SOCIAL SECURITY NO. 519-28-5172B	17. INFORMANT'S OWN SIGNATURE x L. C. Abel	ADDRESS Filer, Idaho		

4379

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral accident	Hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral arteriosclerosis	Years
DUE TO (c)	Generalized arteriosclerosis-	Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Bronchitis	two days

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 24, 1965, *to* July 8, 1969, *that I last saw the deceased alive on* July 8, 1969, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title)	23b. ADDRESS 122 9th Ave. No. Buhl	23c. DATE SIGNED 7-10-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 11, 1969	24c. NAME OF CEMETERY OR CREMATORY Filer IOOF Cemetery	24d. LOCATION (City, town, or county) (State) Filer, Idaho
DATE REC'D BY LOCAL REG. July 18, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Donald J. Hamilton	LICENSE NO. E-470

FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JUL 17 1969 Bureau of Vital Statistics

State File No. 3436
Local Reg. No. D-233
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 431
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Inkom
d. STREET ADDRESS (If rural, give location) R.R.#1 Box 73

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELDON	CLAY	MILLER	July 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married 3	Oct. 2, 1917	51		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction---Morrison-Knudson 11		Springfield, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herbert John Miller		Florence Smith	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	xxxxx 0	519-12-9966	Sudah A. Miller	Inkom, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c) — 4109

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severe Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarction
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Coroner's investigation only *, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Cloya O. Edwards 583	Coroner 4	R.R.#3 Twin Falls, Idaho	7/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	July 12, 1969	Inkom Cemetery	Inkom, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 15, 1969	Marva D. Marsh	Paul D. Reynolds	E-495

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3437
Local Reg. No. D-325
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
DURATION OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1594 4th Ave. East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 421
d. STREET ADDRESS (If rural, give location) 1594 4th Ave. East

3. NAME OF DECEASED (Type or Print) a. (First) DORIS b. (Middle) H. c. (Last) STONE

4. DATE OF DEATH (Month) (Day) (Year) July 8, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 12, 1918
9. AGE (In years last birthday) 50 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Oakley, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Bernice B. Howells BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Dazel Berke BIRTHPLACE Oakley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 519-01-2544
17. INFORMANT'S OWN SIGNATURE X Richard W. Stone ADDRESS (Same as above)

18. CAUSE OF DEATH 9590
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Barbituate Poisoning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Asthma

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) S Suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Twin Falls, 13 Twin Falls, 420 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 8, 1969 5:00a
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Overdose of Sleeping pills

22. I hereby certify that I attended the deceased from Coroner investigation only, 19__, that I last saw the deceased alive on ----------, 19--, and that death occurred at 5:00a m., from the causes and on the date stated above.

23a. SIGNATURE Cloyce O. Edwards 583 (Degree or title) Coroner Twin Falls County 4
23b. ADDRESS Route #3 Twin Falls, Idaho
23c. DATE SIGNED July 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2
24b. DATE July 8, 1969
24c. NAME OF CEMETERY OR CREMATORY Mt. View Crematory
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. July 8, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Donald L. Hamilton Not Embalmed
LICENSE NO. 470

FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 18 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 16 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3438
Local Reg. No. D-231
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 0 0 0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 421
d. STREET ADDRESS (If rural, give location): 1515 Kimberly Rd.

3. NAME OF DECEASED (Type or Print) 143
a. (First): DELBERT
b. (Middle): E.
c. (Last): WARD

4. DATE OF DEATH (Month) (Day) (Year): July 9, 1969

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Feb. 27, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Carpentry

11. BIRTHPLACE (State or foreign country): Edinburg, No. Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward Ward
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Ethel Lovejoy
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 3
(If yes, give war or dates of service): ----0

16. SOCIAL SECURITY NO.: 516-01-7387A

17. INFORMANT'S OWN SIGNATURE: Ronald L. Schumacher
ADDRESS: Twin Falls, Id

18. CAUSE OF DEATH 1519
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Adenocarcinoma of stomach
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 15 June 1969, *to* 8 July, 1969, *that I last saw the deceased alive on* 8 July 1969, *and that death occurred at* 3:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Werner H. Kramer MD
23b. ADDRESS: Twin Falls, Ida
23c. DATE SIGNED: 11 July 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/11/69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: July 14, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Edgar J. Robertson
LICENSE NO.: E-507
FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 15 1969 Bureau of Vital Statistics

State File No. 3439
Local Reg. No. D-229
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 TWIN FALLS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS
STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION MAGIC VALLEY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY TWIN FALLS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 420 FILER
d. STREET ADDRESS (If rural, give location) RURAL # 2

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) 143 MAURICE c. (Last) DUNLAP
4. DATE OF DEATH (Month) (Day) (Year) 7 - 10 - 1969

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3
8. DATE OF BIRTH XX 4-15-1905
9. AGE (In years last birthday) 64
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) FARMINGTON, ARKANSAS
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE F. DUNLAP BIRTHPLACE TENNESSEE
14. MOTHER'S MAIDEN NAME MYRTLE BROOKS BIRTHPLACE ARKANSAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) 2 0
16. SOCIAL SECURITY NO. 519-01-2312
17. INFORMANT'S OWN SIGNATURE & Della Dunlap ADDRESS Filer

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4412

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) INFARCTION OF RECTOSIGMOID
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) RESECTION OF ABDOMINAL AORTIC ANEURYSM
DUE TO (c) DIFUSE, SEVERE ARTERIOSCLEROSIS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/8/69, 19__, to 7/10, 1969, that I last saw the deceased alive on 7/10, 19 69 and that death occurred at 2:10 a.m., from the causes and on the date stated above.

23a. SIGNATURE John McMcClain (Degree or Title) MD
23b. ADDRESS 676 Shoup Ave. W. Twin Falls, Idaho
23c. DATE SIGNED 7/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 7 - 14 - 1969
24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. CEMETERY
24d. LOCATION (City, town, or county) FILER, (State) IDAHO

DATE REC'D BY LOCAL REG. July 11, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Paul B. Reynolds
LICENSE NO. E-495
FIRM NAME: REYNOLDS FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3440
Local Reg. No. D-232
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls — JUL 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (in this place) 888
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazeldel Manor Nursing Home 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 421
d. STREET ADDRESS (If rural, give location) 640 Filer Ave. West

3. NAME OF DECEASED (Type or Print) a. (First) Ernest b. (Middle) c. (Last) White
4. DATE OF DEATH (Month) (Day) (Year) July 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Nov. 18, 1879	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Building Contractor //	Construction	Shepard, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles White	unknown	Elizabeth	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes / Spanish Amer.	518-60-3729	Charles A. Garner	130 Addison Ave. W. Twin Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Complete AV Block — INTERVAL BETWEEN ONSET AND DEATH 4-5 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A.S.H.D — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe Cerebral Arteriosclerosis — 10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/1/57, 19____, *to* 7/10/69, 19____, *that I last saw the deceased alive on* 6/20/69, 19____, *and that death occurred at* 6:20 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
578 M.D	204 4th Ave. E. Twin Falls	7/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Entombment	July 12, 1969	Sunset Memorial Park	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 14, 1969	Marva D. Marsh	Jerry D. Holman	E-516

FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 17 1969

AUG 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

JUN 06 2013

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3441
Local Reg. No. D-334
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH — a. COUNTY: Twin Falls 420 — JUL 17 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls Rural
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Nat-Soo-Pah R.R.#1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE: Idaho — b. COUNTY: T.Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls Rural
d. STREET ADDRESS (If rural, give location): R.R.#3

3. NAME OF DECEASED (Type or Print) — a. (First): RONALD — b. (Middle): GENE — c. (Last): IRISH

4. DATE OF DEATH (Month) (Day) (Year): July 11,1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1

8. DATE OF BIRTH: July 13,1959

9. AGE (In years last birthday): 9 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Jerome, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Irish — BIRTHPLACE: Brockburg, Nebraska

14. MOTHER'S MAIDEN NAME: Jean Irish — BIRTHPLACE: Hazelton, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Jean Irish — ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c) — 9100

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Drowning

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Asphyxiation

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Head trauma

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroner's investigation only *, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at* 9:30p. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eloyce O. Edwards 583 Coroner 4

23b. ADDRESS: R.R.#3 Tw in Falls, Idaho

23c. DATE SIGNED: July 14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/14/69

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: July 15, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: James C. Reynolds — LICENSE NO.: E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3442
Local Reg. No. D-236
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: 430 Twin Falls
JUL 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mt.View Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: T.Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 421
d. STREET ADDRESS (If rural, give location): 1530 Kimberly Road

3. NAME OF DECEASED (Type or Print): a. (First) HARRY; b. (Middle) E.; c. (Last) WINSTON

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1

8. DATE OF BIRTH: February 22, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Farmer 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Shelbyville,Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: W.S.Winston
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Francis Maupin
BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2
(If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 518-44-0068

17. INFORMANT'S SIGNATURE: Twin Falls, ADDRESS: Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — 3 years
DUE TO (c) Emphysema — 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-31-63, 19____, *to* 7/12/, 19 69, *that I last saw the deceased alive on* 7-12-69, 19____, *and that death occurred at* 1:30p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. 1
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 7/15/69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: July 16, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: James C. Reynolds
LICENSE NO.: E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3443
Local Reg. No. D-238
Reg. Dist. No. 460

Certificate of Death

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 4 days 304
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 420
d. STREET ADDRESS (If rural, give location): 309 9th Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First): Catherine 143
b. (Middle): Hattie
c. (Last): Jones

4. DATE OF DEATH (Month) July (Day) 13, (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Jan. 8, 1892
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Chelsea, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Russel — BIRTHPLACE: Oklahoma
14. MOTHER'S MAIDEN NAME: Martha Tripplitt — BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-09-7669B
17. INFORMANT'S OWN SIGNATURE: x Howard Jones — ADDRESS: Buhl, Idaho

18. CAUSE OF DEATH 402X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart Failure, due to Arteriosclerotic Hypertensive heart disease — INTERVAL BETWEEN ONSET AND DEATH: ~~[illegible] days~~ 5 days.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Parkinsons Disease — 8-10 yrs.
DUE TO (c): Cerebral Sclerosis — 5-6 yrs.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-7, 1969, *to* 7-13, 1969, *that I last saw the deceased alive on* July 13, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Vern H Anderson, MD
23b. ADDRESS: Buhl, Ida
23c. DATE SIGNED: 7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Buhl Cemetery
24d. LOCATION (City, town, or county) (State): Buhl Idaho

DATE REC'D BY LOCAL REG.: July 17, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Jim A Hopkins
LICENSE NO.: E-482

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3444
Local Reg. No. D-231
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 6 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 421
d. STREET ADDRESS (If rural, give location) 152 Sidney Street

3. NAME OF DECEASED (Type or Print) a. (First) WALTER b. (Middle) c. (Last) PLACKETT

4. DATE OF DEATH (Month) (Day) (Year) July 13, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH November 3, 1891

9. AGE (In years last birthday) 77
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Custodian 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Burlingame, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George W. Plackett BIRTHPLACE New Jersey

14. MOTHER'S MAIDEN NAME Mary Nichols BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO. 509-03-9469A

17. INFORMANT'S OWN SIGNATURE Mrs. Raymond B. Williams Filer, ADDRESS Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
1. Cerebrovascular arteriosclerotic with repeated small strokes. — 5 yrs+
2. Arteriosclerotic heart disease. — 5 yrs+

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/23, 1967, *to* 7/13/, 1969, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 8:20a. m., *from the causes and on the date stated above.*

23a. SIGNATURE James H. Stafford 489 (Degree or title) M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 7/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/15/69

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. July 17, 1969

REGISTRAR'S SIGNATURE Maria D. Musch

25. EMBALMER James C. Reynolds James C. Reynolds LICENSE NO. E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 2 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. OCT 1 1981

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3445
Local Reg. No. D-237
Reg. Dist. No. 460

Certificate of Death

RECEIVED
JUL 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 421
d. STREET ADDRESS (If rural, give location): 214 Carney Street

3. NAME OF DECEASED (Type or Print)
a. (First): GRACE
b. (Middle): E.
c. (Last): SEARS

4. DATE OF DEATH (Month) (Day) (Year): July 13, 1969

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 16, 1894
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Ritchey — BIRTHPLACE: Durham, Illinois
14. MOTHER'S MAIDEN NAME: Mary Ann Sears — BIRTHPLACE: Burnside, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-30-8188
17. INFORMANT'S OWN SIGNATURE: X Mrs Ralph O. Harrow — ADDRESS: Jerome, Ida.

18. CAUSE OF DEATH 4319
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 31 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3/13, 1969, *to* 7/13, 1969, *that I last saw the deceased alive on* July 13, 1969, *and that death occurred at* 3:10P *m., from the causes and on the date stated above.*

23a. SIGNATURE 422 (Degree or title): Vaughn M. Ford M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: July 15, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: July 16, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Jerry D. Holman
LICENSE NO.: E-516

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 5 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to:

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3446
Local Reg. No. D-235
Reg. Dist. No. 460

RECEIVED JUL 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY IN (If outside corporate limits, write RURAL and give place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural Route #3 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 420
d. STREET ADDRESS (If rural, give location) 1 mile E. & 3/4 mile N.

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) CAROLYN c. (Last) SACKETT

4. DATE OF DEATH (Month) (Day) (Year) July 14, 1969

5. SEX Female

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Nov. 7, 1908

9. AGE (In years last birthday) 60
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY Education

11. BIRTHPLACE (State or foreign country) Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John L. Gillespie
BIRTHPLACE Georgia

14. MOTHER'S MAIDEN NAME Bessie Jane Allison
BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 2
(If yes, give war or dates of service) 0

16. SOCIAL SECURITY NO. 518-48-9508

17. INFORMANT'S OWN SIGNATURE > M. E. Sackett
ADDRESS Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1748

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF BREAST WITH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) METASTASES
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 18 mons.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/10, 19 69, *to* 7/14, 19 69, *that I last saw the deceased alive on* 7/14, 19 69, *and that death occurred at* 4:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE 466 Roy O. Shaub M.D (Degree or title)

23b. ADDRESS 284 Martin St Twin Falls Ida

23c. DATE SIGNED 7/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 17, 1969

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. July 15, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Edgar J. Robertson
LICENSE NO. E-507
FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 9 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3447
Local Reg. No. D-248
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED
420 AUG - 4 1969
325
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
DURATION OF STAY (in this place): 25 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral's Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 420
d. STREET ADDRESS (If rural, give location): 820 Sprague Ave

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY		WHITED	July 14 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	July 15, 1888	80	11	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Grimes, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ples Grimes	unknown	Mattie Ray	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	518-14-1626	Mrs. Vern Whited	Buhl, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Heart failure from	2wks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Left hemiplegia	5yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 12, 1969, *to* July 14, 1969, *that I last saw the deceased alive on* 7-12, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen Henderson, M.D.	Buhl, Ida	7-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 17, 1969	Buhl Cemetery	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 31, 1969	Marva D. Marsh	George Farmer	E-480

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Albertson-Dickard Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3448
Local Reg. No. D-341
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 431 JUL 25 1969
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 Bureau of Vital Statistics
c. LENGTH OF STAY 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 420
d. STREET ADDRESS (If rural, give location) Route #3

3. NAME OF DECEASED (Type or Print)
a. (First) REBECCA
b. (Middle) M.
c. (Last) ARMER

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH November 21, 1894
9. AGE (In years last birthday) 74 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Carroll County, Arkansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME James S. McGehee BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Sophronia Conner BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 2 (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. 573 50 5705
17. INFORMANT'S OWN SIGNATURE Jeff Armer ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Abdominal carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 1 yr +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Atelectasis, lower lobe left lung — 5 mo.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-16, 1968, *to* 7-15, 1969, *that I last saw the deceased alive on* July 15, 1969, *and that death occurred at* 10:25P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 489 James H. Gifford M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 7.16.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 2
24b. DATE 7.18.69
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Harrison, Arkansas

DATE REC'D BY LOCAL REG. July 22, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-470

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3449
Local Reg. No. D-242
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

421 JUL 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial hop.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 626 2nd Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First): ESTELLA
b. (Middle): 143
c. (Last): KELLY

4. DATE OF DEATH (Month) (Day) (Year): July 16, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Dec. 14, 1883
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Carey, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thompson Parke — BIRTHPLACE: Jackson Co. Mo.
14. MOTHER'S MAIDEN NAME: Julia Sessions — BIRTHPLACE: Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 519-
17. INFORMANT'S OWN SIGNATURE: C J Kelly — ADDRESS: Carey Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 3-4 mon.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Generalized Arteriosclerosis, Hiatus Hernia.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/29, 1967, *to* July 16, 1969; *that I last saw the deceased alive on* 7/15, 1969, *and that death occurred at* 7:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 466 Roy O. Shaub M.D.
23b. ADDRESS: 284 Martin St. Twin Falls Idaho
23c. DATE SIGNED: 7/21/69.

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 7/19/1969
24c. NAME OF CEMETERY OR CREMATORY: Carey Cemetery
24d. LOCATION (City, town, or county) (State): Carey, Idaho

DATE REC'D BY LOCAL REG.: July 22, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Keith Bird — LICENSE NO.: E-373

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bird Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 9 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3450
Local Reg. No. D-244
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 28 1969 Bureau of Vital

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 857 Walnut 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 421
d. STREET ADDRESS (If rural, give location): 857 Walnutt

3. NAME OF DECEASED (Type or Print)
a. (First): BESS
b. (Middle): M.
c. (Last): BROWN

4. DATE OF DEATH (Month) (Day) (Year): July 22, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 28, 1881

9. AGE (In years last birthday): 88
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Gregg
BIRTHPLACE: Ireland

14. MOTHER'S MAIDEN NAME: Melda Jane Lowry
BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2
(If yes, give war or dates of service): ---- 0

16. SOCIAL SECURITY NO.: 518-54-1250

17. INFORMANT'S OWN SIGNATURE: Mrs. J. S. Gray
ADDRESS: Twin Falls, Ida

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) a. Acute infarction of myocardium — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) b) arteriosclerotic heart disease — 15 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 13, *19* 69 *to* July 22, *19* 69 *that I last saw the deceased alive on* June 26, *19* 69 *and that death occurred at* 11 P.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 296 Bl. Kirkham M.D.

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 7-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: July 26, 1969

24c. NAME OF CEMETERY OR CREMATORY: Portland Crematory

24d. LOCATION (City, town, or county) (State): Portland, Oregon

DATE REC'D BY LOCAL REG.: July 24, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER

LICENSE NO.: 343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3451
Local Reg. No. D-245
Reg. Dist. No. 460

BIRTH NO.

RECE JUL 28 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 c. LENGTH OF STAY (In this place): 000	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer, 83328 420
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Skyview Manor Nursing Home 273	d. STREET ADDRESS (If rural, give location): Route # 2

3. NAME OF DECEASED (Type or Print) a. (First): Eva	b. (Middle): O.	c. (Last): Mills	4. DATE OF DEATH (Month) (Day) (Year): July 22, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: July 26, 1905	9. AGE (In years last birthday): 63 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Unionville, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George F. Gilworth	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Hattie Smiley	BIRTHPLACE: Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 (If yes, give war or dates of service): 0	16. SOCIAL SECURITY NO.: 523-07-7071	17. INFORMANT'S OWN SIGNATURE: + N. Jay Mills	ADDRESS: Filer, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1940

MEDICAL CERTIFICATION

	INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinomas left adrenal	10 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	
DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 - , 19 68, *to* 7-22, 19 69, *that I last saw the deceased alive on* 7-22, 19 69, *and that death occurred at* 9 25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: 064 Harry F Brumbach (Degree or title) M.D.	23b. ADDRESS: 238 Martin Twin Falls	23c. DATE SIGNED: 7-24-69.
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: July 25, 1969	24c. NAME OF CEMETERY OR CREMATORY: Filer IOOF Cemetery
24d. LOCATION (City, town, or county) (State): Filer, Twin Falls, Idaho		
DATE REC'D BY LOCAL REG.: July 25, 1969	REGISTRAR'S SIGNATURE: Marva D. Marsh	25. EMBALMER: [signature]
LICENSE NO.: E-243		

FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 3 0 1969

MAY 2 6 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3452
Local Reg. No. D-247
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (in this place): 3800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hosp. 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 421
d. STREET ADDRESS (If rural, give location): Route # 2

3. NAME OF DECEASED (Type or Print)
a. (First): Susie
b. (Middle):
c. (Last): Price

4. DATE OF DEATH (Month) (Day) (Year): July 22, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 28, 1917
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Artas, South Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel Schweigert — BIRTHPLACE: Russia
14. MOTHER'S MAIDEN NAME: Elizabeth Huber — BIRTHPLACE: Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 566-20-1755
17. INFORMANT'S OWN SIGNATURE: John Price — ADDRESS: Twin Falls, Ida.

18. CAUSE OF DEATH 354X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Guillain-Barré Disease — INTERVAL BETWEEN ONSET AND DEATH: 5-29-69

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Aspiration Pneumonia — 7-1-69
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-29, 1969, *to* 7-22, 1969, *that I last saw the deceased alive on* 7-22, 1969, *and that death occurred at* 5:45pm *m., from the causes and on the date stated above.*

23a. SIGNATURE 431 (Degree or title): Elwood T. Rusch
23b. ADDRESS: Twin Falls Idaho
23c. DATE SIGNED: 7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 26, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: July 30, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Ronald J. Hamilton
LICENSE NO.: E-470

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary Twin Falls, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3453
Local Reg. No. D-246
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
c. LENGTH OF STAY (In this place) 800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. View Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly 420
d. STREET ADDRESS (If rural, give location) 811 Polk Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELSIE	LURA	HANES	July 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	April 21, 1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Piney Creek, North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jesse Waddell — BIRTHPLACE North Carolina
14. MOTHER'S MAIDEN NAME unknown — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) 2
16. SOCIAL SECURITY NO. 518-26-4675
17. INFORMANT'S OWN SIGNATURE Robert A. Hanes, ADDRESS Twin Falls, Idaho

4409

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease 10 yrs,
DUE TO (c) Carcinoma of Uterus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 19 51, *to* 7/23/, 1969, *that I last saw the deceased alive on* 7-23, 1969, *and that death occurred at* 8:40p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.
23b. ADDRESS Kimberly, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/25/69
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-29-69
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER James C. Reynolds — LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3454
Local Reg. No. D-255
Reg. Dist. No. 460

Certificate of Death

RECEIVED AUG 12 1969

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (in this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 820 Sprague Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): MARTHA
b. (Middle): A.
c. (Last): HIGGINS

4. DATE OF DEATH (Month) (Day) (Year): July 30, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 13, 1877
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Davenport, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William A. Martin — BIRTHPLACE: DeWitt, Iowa
14. MOTHER'S MAIDEN NAME: Bridgett Kennedy — BIRTHPLACE: Boston, Mass.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No 2 — (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.: 518-22-8080 J1
17. INFORMANT'S OWN SIGNATURE: Gerald J Higgins — ADDRESS: Box 1168 Salmon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3-4 wks

ANTECEDENT CAUSES — from Arteriosclerotic Heart — 10 yrs.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Disease.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jun, 1969, *to* July 30, 1969 *that I last saw the deceased alive on* July 23 1969, *and that death occurred at* 3:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 011 Vern H Anderson MD
23b. ADDRESS: Buhl, Idaho
23c. DATE SIGNED: 7-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/1/69
24c. NAME OF CEMETERY OR CREMATORY: Buhl
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 8-7-69
REGISTRAR'S SIGNATURE: Vera Ryals
25. EMBALMER: George Farmer
LICENSE NO.: E-480

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3455
Local Reg. No. D-249
Reg. Dist. No. 460

RECEIVED
Bureau of Vital Statistics
AUG - 4 1969

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Twin Falls 421 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 — c. LENGTH OF STAY (In this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Twin Falls — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 421 — d. STREET ADDRESS (If rural, give location): Camera Center Hotel

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROBERT	P.	NOH	July 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	Jan. 14, 1922	47				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Three Creek, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harry Noh	Clarkson, Nebraska	Grace Kearley	Crossville, Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes 1	WWII 4109	519-16-3488	Harry W. Noh	Kooperson, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Coroner Investigation only *19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 7:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Floyce O. Edwards 583	Coroner Twin Falls County 4	Route # 3 Twin Falls, Ida.	7/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 2, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 31, 1969	Marva D. Marsh	[signature]	E 343

FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3456
Local Reg. No. D-251
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 AUG 8 1969 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY IN THIS PLACE 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hosp. 143

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 421
d. STREET ADDRESS (If rural, give location) 412 Fifth Avenue North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRANCES	BLANCHE	JOHNSON	July 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married 3	June 5, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 04	Own home	Antelope, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eli Clark Adams	Ohio	Effie Jane Oursler	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2 - - - 0 - - -	481-03-7932B	Betty Jane Robertson	New Orleans, La.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) obstructive Carcinoma Colon 1538 — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) & perforation & generalized Carcinosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-20, 1969, *to* 8-31, 1969; *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 10:45a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	238 [illegible]	8-4-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 4, 1969	Sunset Memorial Pk.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-6-69	Vera Ryals	Dale P. Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3457
Local Reg. No. D-250
Reg. Dist. No. 460

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 421 AUG 8 1969
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If in hospital or institution) 880
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 421
d. STREET ADDRESS (If rural, give location) 436 5th Ave. E.

3. NAME OF DECEASED (Type or Print) 143
a. (First) INEZ
b. (Middle) ESTHER
c. (Last) ROSS

4. DATE OF DEATH (Month) (Day) (Year) July 31, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 63
8. DATE OF BIRTH Aug. 9, 1894
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Homemaking
11. BIRTHPLACE (State or foreign country) Burden, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME unk. Cunningham — BIRTHPLACE Ireland
14. MOTHER'S MAIDEN NAME unk. — BIRTHPLACE unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 2 — (If yes, give war or dates of service) ---- 0
16. SOCIAL SECURITY NO. 518-34-3297A
17. INFORMANT'S OWN SIGNATURE John W. Ross — ADDRESS Twin Falls

18. CAUSE OF DEATH 4310
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-26-69, 19__, *to* 7-31, 1969, *that I last saw the deceased alive on* 7-31-, 1969, *and that death occurred at* 10:35a *m., from the causes and on the date stated above.*

23a. SIGNATURE A. W. Kendall M.D. 277 (Degree or title)
23b. ADDRESS 206 Martin St., Twin Falls Idaho
23c. DATE SIGNED 8.2.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/2/1969
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. August 4, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Donald J. Hamilton
LICENSE NO. E-470

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary Twin Falls, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 25 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 21 1984

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3458
Local Reg. No. 3
Reg. Dist. No. 3/8

Certificate of Death

RECEIVED AUG 6 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 430
a. COUNTY: Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): McCall Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Roy
c. (Last): Cheverton

4. DATE OF DEATH (Month) 6 (Day) 27 (Year) 1969

5. SEX: male
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 5/1/1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): pilot 10
10b. KIND OF BUSINESS OR INDUSTRY: aviation
11. BIRTHPLACE (State or foreign country): Dansville, New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ------ BIRTHPLACE: -----
14. MOTHER'S MAIDEN NAME: ------ BIRTHPLACE: -------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: X. Navah L. Cheverton — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cardiac shock syndrome — INTERVAL BETWEEN ONSET AND DEATH: 6h.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Ventricular tachycardia — 6h.
DUE TO (c) Acute myocardial infarction — 12h.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-26, 1969, *to* 6-27, 1969, *that I last saw the deceased alive on* 6-27, 1969, *and that death occurred at* 10³⁰/a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wayne Allen MD (Degree or title) 006
23b. ADDRESS: McCall, Idaho
23c. DATE SIGNED: 6/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): rem-burial
24b. DATE: 7/1/69
24c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery
24d. LOCATION (City, town, or county) (State): Council Adams Idaho

DATE REC'D BY LOCAL REG.: July-23-1969
REGISTRAR'S SIGNATURE: Myrtle M. Gardner
25. EMBALMER: L. Dave Thomason
LICENSE NO.: E 388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3459
Local Reg. No. 2
Reg. Dist. No. 3/0

BIRTH NO.

RECEIVED JUL 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
c. LENGTH OF STAY in this place: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): McCall 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2820 Teton

3. NAME OF DECEASED (Type or Print): a. (First) ROLAND b. (Middle) VAUGHN c. (Last) BATES

4. DATE OF DEATH: (Month) (Day) (Year) July 7, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 15, 1918

9. AGE (In years last birthday): 50
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Data Processing 26

10b. KIND OF BUSINESS OR INDUSTRY: Manager

11. BIRTHPLACE (State or foreign country): Murtaugh, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lyman Bates — BIRTHPLACE: Marion, Idaho

14. MOTHER'S MAIDEN NAME: Sarah Edith Lee — BIRTHPLACE: Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes / (If yes, give war or dates of service): W.W.II 4

16. SOCIAL SECURITY NO.: 518-18-2889

17. INFORMANT'S OWN SIGNATURE: x Maida E. Bates — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): coronary thrombosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): natural

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): summer home

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): McCall, Valley, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 7, 1969 Aft.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *, to* _____ *, 19* _____ *, that I last saw the deceased alive on* _____ *, 19* _____ *, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Burton E. Walker, CORONER 4

23b. ADDRESS: McCall, Idaho

23c. DATE SIGNED: 7/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-10-1969

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: July-17-1969

REGISTRAR'S SIGNATURE: Haydee A Gardner

25. EMBALMER: Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3460
Local Reg. No. 1
Reg. Dist. No. 310

BIRTH NO.

430 JUL 28 1969 307

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Valley	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: California 05 b. COUNTY: Shasta 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural Yellow Pine c. LENGTH OF STAY (In this place): 7 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Redding
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cox Dude Ranch 000	d. STREET ADDRESS (If rural, give location): 1505 Riverside Drive

3. NAME OF DECEASED (Type or Print) a. (First): PARKER	b. (Middle): LOWRY	c. (Last): GETCHELL	4. DATE OF DEATH (Month) (Day) (Year): July 8, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: March 30, 1910	9. AGE (In years last birthday): 59 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Engineer 10	10b. KIND OF BUSINESS OR INDUSTRY: So. Pacific R R	11. BIRTHPLACE (State or foreign country): Shasta County, Calif.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Jesse H. Getchell	BIRTHPLACE: Shasta Co, Cal.	14. MOTHER'S MAIDEN NAME: Katherine Weston	BIRTHPLACE: California	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 (If yes, give war or dates of service): 0	16. SOCIAL SECURITY NO.: 553-03-9124	17. INFORMANT'S OWN SIGNATURE: Elsie H. Getchell	ADDRESS: Redding, California	

185X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Carcinoma of prostate with extensive metastasis	4 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): natural	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Cox Dude Ranch	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): rural Yellow Pine, Valley Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 8, '69 - 6:30 A. m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *19 to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton E. Walker 583 (Degree or title): Coroner 4	23b. ADDRESS: McCall, Idaho	23c. DATE SIGNED: 7/8/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: 7/14/69	24c. NAME OF CEMETERY OR CREMATORY: Millville, Cemetery	24d. LOCATION (City, town, or county) (State): Shasta County, California
DATE REC'D BY LOCAL REG.: July-9-1969	REGISTRAR'S SIGNATURE: Myrtle M. Gardner	25. EMBALMER: Burton E. Walker	LICENSE NO.: E-386

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 4 1969
JUL 2 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended Sept 16, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3461
Local Reg. No. 4
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
c. LENGTH OF STAY (In this place): 2 WKS 314
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Co. Mem. Hosp. 152

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
d. STREET ADDRESS (If rural, give location): Box 149

3. NAME OF DECEASED (Type or Print): a. (First) Milton; b. (Middle) Harlan; c. (Last) Greenlee

4. DATE OF DEATH: (Month) July (Day) 13, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 9, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister 18

10b. KIND OF BUSINESS OR INDUSTRY: Religion

11. BIRTHPLACE (State or foreign country): Fort Smith, Arkansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alvin Clark Greenlee
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Carrie Lovina Tucker
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1
(If yes, give war or dates of service): WW 1 3

16. SOCIAL SECURITY NO.: 519-38-1551

17. INFORMANT'S OWN SIGNATURE: Edna P. Greenlee
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Metastatic Carcinoma — 6 Mths
DUE TO (c): Carcinoma of Colon — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1964

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Colon

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) Cascade (COUNTY) Valley (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1954, 19__, *to* July 13, 1969, *that I last saw the deceased alive on* July 13, 19 69, *and that death occurred at* 5 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: John F. Moser, M.D. 376
(Degree or title) 1

23b. ADDRESS: Cascade, Idaho

23c. DATE SIGNED: 7-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1

24b. DATE: July 16, 1969

24c. NAME OF CEMETERY OR CREMATORY: Alpha Cemetery

24d. LOCATION (City, town, or county) (State): Valley Co, Idaho

DATE REC'D BY LOCAL REG.: July 24, 1969

REGISTRAR'S SIGNATURE: Myrtle M. Gardner

25. EMBALMER: Glenn W. Beatty

LICENSE NO.: E 392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
SEP 16 1969
Bureau of Vital Statistics

State of Idaho
County of Gem } ss.

Certificate No. 69-3461

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Milton Harlan Greenlee (Name on Original Certificate) who died (Was Born or Died) on July 13, 1969 (Date of Event)
in Cascade, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#24b Date of Burial	June 16, 1969	July 16, 1969

Subscribed and sworn to before me this 13 day of September, 1969.

Jean A Beatty

Notary Public, residing at Emmett Idaho

My commission expires 7-21-70

(Seal)

Signed Glenn W Beatty
(Signature of parent or attendant if correcting a birth record; or attendant, funeral director, informant if correcting a death record; or other credible person.)

242 E. Main Emmett, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Gem } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 13 day of September, 1969.

Jean A Beatty

Notary Public, residing at Emmett, Idaho

My commission expires 7-21-70

(Seal)

Signed Walter J Potter
(Signature of Any Credible Person)

228 E Main Emmett Idaho
(Street Address, City, State)

FORM DH 50-155

9-1-69

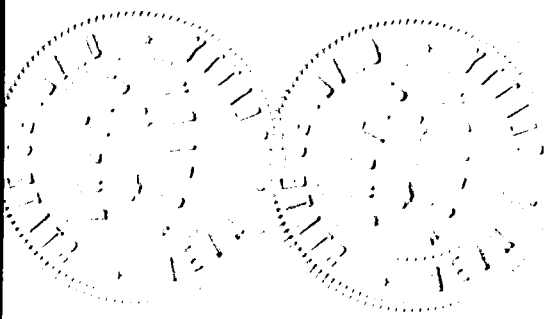

Certificate of Death

STATE OF IDAHO

State File No. 3461
Local Reg. No. 3/0
Reg. Dist. No.

RECEIVED AUG 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
c. LENGTH OF STAY IN (this place): 2wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Co. Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
d. STREET ADDRESS (If rural, give location): Box 149

3. NAME OF DECEASED (Type or Print): a. (First) Milton b. (Middle) Harlan c. (Last) Greenlee

4. DATE OF DEATH (Month) (Day) (Year): July 13, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: June 9, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): minister

10b. KIND OF BUSINESS OR INDUSTRY: religion

11. BIRTHPLACE (State or foreign country): Fort Smith, Arkansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alvin Clark Greenlee
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Carrie Lovina Tucker
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 519 38 1551

17. INFORMANT'S OWN SIGNATURE: X Edna P. Mrs Greenlee
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): METASTATIC CARCINOMA — 6 MTHS

DUE TO (c): CARCINOMA OF COLON — 5 YRS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1964

19b. MAJOR FINDINGS OF OPERATION: CARCINOMA OF COLON

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): CASCADE VALLEY IDA

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1954, 19__, *to* JULY 13 1969, *that I last saw the deceased alive on* JULY 13, 1969, *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. J. Moore MD

23b. ADDRESS: CASCADE, IDA

23c. DATE SIGNED: 7/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: June 16, 1969

24c. NAME OF CEMETERY OR CREMATORY: Alpha Cemetery

24d. LOCATION (City, town, or county) (State): Valley Co. Idaho

DATE REC'D BY LOCAL REG.: July 24-1969

REGISTRAR'S SIGNATURE: Myrtle M. Gardner

25. EMBALMER: Glenn W Beatty

LICENSE NO.: E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 5 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3462
Local Reg. No. 5
Reg. Dist. No. 310

BIRTH NO.

RECEIVED AUG 6 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Valley 430	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Crouch c. LENGTH OF STAY (In this place): 400 few hrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Near Silver Springs Resort 000	d. STREET ADDRESS (If rural, give location): 1312 E. Washington

3. NAME OF DECEASED (Type or Print) a. (First): Walter	b. (Middle): C.	c. (Last): Mittelsteadt	4. DATE OF DEATH (Month) (Day) (Year): July 25, 1969		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: July 6, 1894	9. AGE (In years last birthday): 75	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Nebraska	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Richard Mittelsteadt	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Cora Stevens	BIRTHPLACE: New York		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 1	(If yes, give war or dates of service): W.W. I 3	16. SOCIAL SECURITY NO.: 519-14-1951	17. INFORMANT'S OWN SIGNATURE: [signature]	ADDRESS: 1312 E. Washington Boise, Idaho	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): apparent heart attack — INTERVAL BETWEEN ONSET AND DEATH: seconds

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): coronary occlusion

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): natural	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): rural Crouch	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): rural Crouch Valley Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): early A. M.-7/25/69 m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR? heart attack while on vacation	

22. *I hereby certify that I attended the deceased from _____ 19__ to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

INVESTIGATION ONLY

23a. SIGNATURE: Burton E Walker 583	(Degree or title): Coroner 4	23b. ADDRESS: McCall, Idaho	23c. DATE SIGNED: 7/30/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1	24b. DATE: July 29, 1969	24c. NAME OF CEMETERY OR CREMATORY: Riverside	24d. LOCATION (City, town, or county) (State): Emmett, Idaho
DATE REC'D BY LOCAL REG.: Aug-4-1969	REGISTRAR'S SIGNATURE: Myrtle M Gardner	25. EMBALMER: Robert G. Ross	LICENSE NO.: E-497

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Summers Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 7 1969

OCT 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3463
Local Reg. No. 6
Reg. Dist. No. 310

BIRTH NO.

RECEIVED AUG 21 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Valley 430 313
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
c. LENGTH OF STAY (In this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
AMANDA		JACQUES	July 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	Aug 27, 1883	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Chippewah Falls, Wis.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alfred	no record	Lina	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2 0	519-66-2572	Hospital records	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c). 4369

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) BRONCHOPNEUMONIA

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CONGESTIVE HEART FAILURE
DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DISEASE.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19 66, *to* JULY 30, 19 69, *that I last saw the deceased alive on* JULY 30, 19 69, *and that death occurred at* 11:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
391 Donald S. Hoke M.D.	McCall, Idaho	8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug 2, 1969	Hillcrest	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5 1969	Myrtle A. Gardner	Burton C. Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 10 1969 Bureau of Vital Statistics

State File No. 3464
Local Reg. No. 1
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH 441
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser, 441
d. STREET ADDRESS (If rural, give location): 1105 W. 3rd

3. NAME OF DECEASED (Type or Print) 153
a. (First): Seihichi
b. (Middle): --
c. (Last): Matsumoto

4. DATE OF DEATH (Month) 7 (Day) 1 (Year) 1969

5. SEX: male
6. COLOR OR RACE: Japanese
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married /
8. DATE OF BIRTH: 4/12/1876
9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): trainman 10
10b. KIND OF BUSINESS OR INDUSTRY: UPRR
11. BIRTHPLACE (State or foreign country): Maruyumi, Yamaguchiken Japan
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ------ BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: ------ BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 (If yes, give war or dates of service): 0
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ida Terashima — ADDRESS: Rt #1 - Weiser

18. CAUSE OF DEATH 5901
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Acute pyelonephritis — 3 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: A.H.D. — 15 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/21, 1967, *to* 7/1, 1969, *that I last saw the deceased alive on* 7/1, 1969, *and that death occurred at* 10:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 186 [illegible]
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 7/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 7/3/69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest
24d. LOCATION (City, town, or county) (State): Weiser Washington Ida.

DATE REC'D BY LOCAL REG.: 7-1-69
REGISTRAR'S SIGNATURE: R. Dave Thomason
25. EMBALMER: R. Dave Thomason
LICENSE NO.: E 388

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 10 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3465
Local Reg. No. 3
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
JUL 17 1969
Bureau of Vital Statistics

441

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser 441
d. STREET ADDRESS (If rural, give location): Park Haven Manor

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	HENRY	CLAYTON	WOLLEN		July	7	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Dec. 8, 1880	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miller 17	Milling	Clay County, Nebraska	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No 2	0	4379	Mrs Claude Smith	Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	C.A.	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cerebral Arteriosclerosis	
DUE TO (c)	Gen. Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			m.		

22. *I hereby certify that I attended the deceased from* 6-22-, 1969, *to* 7-7-, 1969, *that I last saw the deceased alive on* 7-7-, 1969 *and that death occurred at* 8:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W.S. McGeath MD	Weiser, Idaho	July 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 10, 1969	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 7, 1969	K. Dee Thomsen	Marshall S. Dickerson Jr.	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
JUL 17 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3466
Local Reg. No. 2
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 441 Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser 441
d. STREET ADDRESS (If rural, give location): 513 E. Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	WALTER	A.	MCROSE	July	11	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 14, 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Realtor 34
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Theodore McRose — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Doris Walter — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 512-20-2911
17. INFORMANT'S OWN SIGNATURE: Helene McRose — ADDRESS: Weiser

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute coronary occ — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arterial HD — 5 y
DUE TO (c): Gen arteriosclerosis — 10 y

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Congestive failure

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/10, 1969, *to* 7/11, 1969 *that I last saw the deceased alive on* 7/11, 1969, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: July 11/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: July 16/69
24c. NAME OF CEMETERY OR CREMATORY: Mt. View Crematory
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: July 11, 1969
REGISTRAR'S SIGNATURE: R. Dan Thomson
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E-464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3467
Local Reg. No. 4
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JUL 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ELMER	FREDRICK	OWENS		July	12	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 5, 1907	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Weiser, Idaho
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME George W. Owens BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME Mary Westerfelt BIRTHPLACE ----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Ruth E Owens ADDRESS Weiser, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic H.D
DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/12, 1969 *to* 7/12, 1969, *that I last saw the deceased alive on* 7/12, 1969, *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 186
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED July 12, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 17, 69
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. July 12, 1969
REGISTRAR'S SIGNATURE K. Dee Thomason
25. EMBALMER Marshall S. Dickenson LICENSE NO. E-464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 24 1969

AUG 20 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 22 2008

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3468
Local Reg. No. 5
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
JUL 23 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 440 Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): rural Weiser
c. LENGTH OF STAY (in this place): 888
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home-upper Monroe Creek

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: W ashington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 440 rural Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Henry	Wavrick	7	19	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	married 3	11/1/1885	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher 04	agriculture	Pittsburg, Penn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Wavrick	Bohemia	Anna Marie Seamen	Bohemia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no 2	0	955-X	Mrs James C Wallcraft	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Death was due to a self inflicted — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) gunshot wound in the throat.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
suicide 2	home 01	rural 73 Weiser Washington Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
7	19	69	m.		Self inflicted gunshot wound

22. *I hereby certify that I attended the deceased from* Coroner's investigation, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
K. Dale Thomson 583 Wash. Co. Coroner 4	Weiser, Idaho	7/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	7/23/69	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-69	K. Dale Thomson	Marshall S Dickenson	E 464

FIRM NAME Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3469
Local Reg. No. 6
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JUL 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser 441
d. STREET ADDRESS (If rural, give location) Park Haven Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Koichi		Shigeyoshi	7	21	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	Japanese	never married	5/21/1883	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
gardening 06	private homes	Kagoshima, Japan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
-----	-----	------	-----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	0	4369	[signature]	Weiser, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-21-, 1969, *to* 7-21-, 1969, *that I last saw the deceased alive on* 7-21-, 1969, *and that death occurred at* 2:19P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Weiser, Idaho	7/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
cremation	7/23/69	Mountain View Crematory	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-21-69	L. Dale Thomason	L. Dale Thomason	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 19 1969
Bureau of V

Certificate of Death
STATE OF IDAHO

State File No. 3470
Local Reg. No. 8
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 910 E. Court

3. NAME OF DECEASED (Type or Print): a. (First) Mayme b. (Middle) O. c. (Last) Hill

4. DATE OF DEATH: (Month) 7 (Day) 25 (Year) 1969

5. SEX: female

6. COLOR OR RACE: caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: 4/26/1886

9. AGE (In years last birthday): 83 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Glenview, Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: August Zieman — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Bertha Haack — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no 2 | (If yes, give war or dates of service): 0

16. SOCIAL SECURITY NO.: 518-07-5068

17. INFORMANT'S OWN SIGNATURE: X Robert O. Hill — ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Chr Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-22-, 1969, *to* 7-25-, 1969, *that I last saw the deceased alive on* 7-25, 1969, *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): M.D.

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: 7/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 7/28/69

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Weiser Washington Idaho

DATE REC'D BY LOCAL REG.: 7-25-69

REGISTRAR'S SIGNATURE: R. Dee Thomsen

25. EMBALMER: R. Dee Thomsen — LICENSE NO.: E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECE

Certificate of Death

STATE OF IDAHO

State File No. 3471
Local Reg. No. 7
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH 440 AUG 5 1969
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brownlee Dam
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Brownlee Dam 000

Bureau of Vital Statistics
Washington County

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma 140
d. STREET ADDRESS (If rural, give location): Box 465

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Archie	Clayton	Tuttle	July 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 11, 1891	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Dixon, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Orrin Clayton Tuttle	Unknown	Emma Brown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	0	518-10-7556	Leo Tuttle	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction acute — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] Stark 804	MD	Parma Idaho	7-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 29, 1969	Parma Cemetery	Parma, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-29-69	D. Dale Thomason	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: AUG 1 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3472
Local Reg. No. 561
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 SEP 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 304 E. 34th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LAWRENCE	S.	WOODYARD	July 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 9, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer //	Construction	Terril, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William H. Woodyard	Iowa	Retta Burt	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	482-01-6764	X Mrs. Lawrence Woodyard	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Emphysema

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-1-20, 1965, to 7-7, 1969, that I last saw the deceased alive on 7-7-69, 1969, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 351	MD	Boise Idaho	8-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/10/69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3 1969	Myrtle Palmer	C. J. Nassar	E535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38.206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 - 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

BIRTH NO. 69-3212 RECEIVED SEP 10 1969 Bureau of Vital Statistics

State File No. 3473
Local Reg. No. 575
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 14 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2607 N orth 36th.

3. NAME OF DECEASED (Type or Print): a. (First) DENNIS b. (Middle) MICHAEL c. (Last) ZANDERS

4. DATE OF DEATH (Month) (Day) (Year): July 19, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: April 17, 1969
9. AGE (In years last birthday): IF UNDER 1 YR. Months 3 Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02
10b. KIND OF BUSINESS OR INDUSTRY: Child
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leonard Gayle Zanders BIRTHPLACE: Boise, Idaho
14. MOTHER'S MAIDEN NAME: Mary Whitmire BIRTHPLACE: Caldwell, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: R Leonard Gayle Zanders ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7463

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Inter Ventricular Septal Defect — INTERVAL BETWEEN ONSET AND DEATH: Congenital

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 7-18-69
19b. MAJOR FINDINGS OF OPERATION: Ventricular Septal Defect & Pulmonary Over-Circulation
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-10, 1969, to 7-19, 1969, that I last saw the deceased alive on 7-19, 1969, and that death occurred at 4:12 P m., from the causes and on the date stated above.

23a. SIGNATURE: Rodney H Hen (Degree or title) M.D.
23b. ADDRESS: 123 E. Idaho.
23c. DATE SIGNED: 9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Sept. 9. 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson
LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3474
Local Reg. No. 578
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 11 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 Hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ontario
d. STREET ADDRESS (If rural, give location): 408 SE 1st Street King Apt.

3. NAME OF DECEASED (Type or Print): a. (First) Francisco; b. (Middle); c. (Last) Hernandez Jr.

4. DATE OF DEATH: (Month) July (Day) 20 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Spanish

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: May 30, 1946

9. AGE (In years last birthday): 23
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Francisco Hernandez Sr
BIRTHPLACE: UNK

14. MOTHER'S MAIDEN NAME: Felipa Gonzalez
BIRTHPLACE: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 539-42-2298

17. INFORMANT'S OWN SIGNATURE: Victoria Bravo
ADDRESS: Ontario, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Gun Shot Wound to Head — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Cerebral Damage

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): /

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 31

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-20-69 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-20, 19 69 *to* 7-20, 19 69, *that I last saw the deceased alive on* 7-20, 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M H King MD

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 24 1969

24c. NAME OF CEMETERY OR CREMATORY: St. Johns

24d. LOCATION (City, town, or county) (State): Ontario Oregon

DATE REC'D BY LOCAL REG.: Sept. 10, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: John A. Bertelsen-Lienkaemper

LICENSE NO.: Ore226

FIRM NAME: Bertelson-Lienkaemper

Federal Security Agency
United States Public Health Service

Form DH-63021

MAR 16 1981

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3475
Local Reg. No. 564
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011 SEP 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 2026 JACKSON

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO 13 b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 2026 JACKSON

3. NAME OF DECEASED (Type or Print) a. (First) VENA b. (Middle) FRAULEY c. (Last) DENIS

4. DATE OF DEATH (Month) (Day) (Year) July 25, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 24, 1882

9. AGE (In years last birthday) 86
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Lexington, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Jacobson
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Katherine Lamma
BIRTHPLACE Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ----------

16. SOCIAL SECURITY NO. 518-54-6069

17. INFORMANT'S OWN SIGNATURE Ruth Broderick
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Cerebral Arteriosclerotic disease.

INTERVAL BETWEEN ONSET AND DEATH: prepsuna.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 19, 1969, to July 25, 1969, that I last saw the deceased alive on July 19, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS 210 No Orchard Boise

23c. DATE SIGNED 8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-28-1969

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery

24d. LOCATION (City, town, or county) Boise Ada (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 2, 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Eldon T. Pearson

LICENSE NO. E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3476
Local Reg. No. 510
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada AUG 7 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Country Club

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 4035 Mountain View Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RICHARD	WILLIAM	CHIPMAN	August 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 3, 1925	44		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Director Non-Foods Merch. 26	Albertsons	Meridian, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Vernie R. Chipman	Arisby, Iowa	Eula Mae Phillips	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. II	519-16-8724	Vernon R. Chipman	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See, to Alive, 19, *that I last saw the deceased alive on* , 19 *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Eldon Pearson	Coroner	3720 Meadow Drive, Boise	8-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-5-1969	Cloverdale Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 7 1969	Myrtle Palmer	Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. _____
Local Reg. No. 510
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Country Club

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4035 Mountain View Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RICHARD	WILLIAM	CHIPMAN	August 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 3, 1925	44		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Director	Non-Foods Merch.	Albertsons Meridian, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Vernie R. Chipman	Arisby, Iowa	Eula Mae Phillips	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.II	519-16-8724	X Marlene Chipman	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) Record of Cardiac Condition. Medicine. for same. — Weeks.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See to Alive, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise,	8-7-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-5-1969	Cloverdale Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 7, 1969	Myrtle Palmer	Eldon T. Pearson	E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 7 1969

AUG 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3477
Local Reg. No. 515
Reg. Dist. No. 370

BIRTH NO.

RECEIVED Bureau of Vital Statistics AUG 13 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 01

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1306 Broxon

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada 01

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho

d. STREET ADDRESS (If rural, give location): 1306 Broxon

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	Fructuosa	Marie	Orbea

4. DATE OF DEATH: (Month) August (Day) 2, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	April 16, 1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Wife	Ea Vizcage, Spain	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pedro Laurieia	Spain	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	518-38-4074	Edward C Orbea	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Stroke, with Ruptured Thoracic	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Aorta. Hemorrhage.	Brief.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 11P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise	8-4-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 7, 1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 8, 1969	Myrtle Palmer	Eric V. Gibson	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3478
Local Reg. No. 509
Reg. Dist. No. 270

BIRTH NO.

RECEIVED AUG 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 511
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (At this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: D.O.A. St. Lukes Hosp. 102

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1319 N. 23rd St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lydia	Q	Springer	Aug. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Dec. 15, 1888	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Huston, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arnold D. Quantrell	England	Aline A. Luthy	France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-40-2658	x Margaret Q. Riley	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH (?) years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5-13-66, 19__, *to* 6-13, 1969, *that I last saw the deceased alive on* 6-13, 1969, *and that death occurred at* __m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul F. Miner 3rd, MD	1333 W. Jefferson Boise Idaho	8/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 5, 1969	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5, 1969	Myrtle Palmer	A. E. Alden	299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1969

FEB 9 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3479
Local Reg. No. 513
Reg. Dist. No. 370

Certificate of Death

RECEIVED
AUG 11 1969
Bureau of V...

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 503

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Madras
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Le Roy
b. (Middle):
c. (Last): Tomlinson

4. DATE OF DEATH (Month) (Day) (Year): Aug. 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 7, 1928
9. AGE (In years last birthday): 40
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant Patrolman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boumont, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas F. Tomlinson
BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Dora E. Chapman
BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE Madras, Oregon ADDRESS: Carlene C. Tomlinson

18. CAUSE OF DEATH 5329
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drug overdose — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Duodenal Ulcer — Several Months

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-27, 1969, *to* 8-3, 1969, *that I last saw the deceased alive on* 8-3, 1969, *and that death occurred at* 8:31A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John B. Hammett MD 595
23b. ADDRESS: 3107 Ridgeway, Boise, Idaho
23c. DATE SIGNED: 8-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-7-69
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Aug. 11, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo. Jerrell
LICENSE NO.: E. 366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

3.cc DUTIES:

AUG 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defired by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3480
Local Reg. No. 572
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 7 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital	d. STREET ADDRESS (If rural, give location): 1715 North 18th Street

3. NAME OF DECEASED (Type or Print)	a. (First): DEAH	b. (Middle): ELIZA	c. (Last): AZCUENAGA	4. DATE OF DEATH (Month) August (Day) 4 (Year) 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: July 21, 1901	9. AGE (In years last birthday): 68 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Eddyville, Iowa	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: W. W. Jones	BIRTHPLACE: Iowa	14. MOTHER'S MAIDEN NAME: Clara Mintonya	BIRTHPLACE: ------	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-07-7436B	17. INFORMANT'S OWN SIGNATURE: Louis A Azcuenaga	ADDRESS: 1715 N. 18th Boise, Idaho	

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary heart disease	10+ yrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Rheumatic heart disease	30 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-16, 1953, *to* 8-4, 1969, *that I last saw the deceased alive on* 8-4, 1969, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner (Degree or title) MD.	23b. ADDRESS: 1333 W. Jefferson St Boise, Idaho	23c. DATE SIGNED: 8/7/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug. 7, '69	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cem.	24d. LOCATION (City, town, or county): Boise Ada (State): Idaho
DATE REC'D BY LOCAL REG.: August 8, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Robert G. Ross	LICENSE NO.: E-497

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG - 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3481
Local Reg. No. 511
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 30 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4701 Fenton

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4701 Fenton

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
AGNES	GRACE	GOE	August 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	9-23-1911	57		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Carson City, Nevada	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wm. Murphy	No Record	Grace Hoppie	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	519-62-5947	X Grant Goe	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

-4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Record of Cardiac Condition. — Months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 645A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise	8-7-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-7-1969	Syringa Gardens	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 7 1969	Myrtle Palmer	Elden T. Pearson	E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
AUG 29 1969
Bureau of Vital Statistics

State File No. 3482
Local Reg. No. 548
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place) 2 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital	d. STREET ADDRESS (If rural, give location) 121 Main Street

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) Catherine	c. (Last) LEMP	4. DATE OF DEATH (Month) (Day) (Year) Aug. 4, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH April 13, 1908	9. AGE (In years last birthday) 61; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher	10b. KIND OF BUSINESS OR INDUSTRY education	11. BIRTHPLACE (State or foreign country) Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert F. Lemp	BIRTHPLACE Boise, Idaho	14. MOTHER'S MAIDEN NAME Marguerite Nolan	BIRTHPLACE Roscommon, Mich.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE X John Lemp	ADDRESS Washington, D.C.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-2-69, *to* 8-4, 1969, *that I last saw the deceased alive on* 8-4-69, *and that death occurred at* 7:55 PM *from the causes and on the date stated above.*

23a. SIGNATURE W. D. Forney (Degree or title) 173 M.D.	23b. ADDRESS 425 Bannock Boise	23c. DATE SIGNED 8-20-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-9-69	24c. NAME OF CEMETERY OR CREMATORY Pioneer Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. 8-25-69	REGISTRAR'S SIGNATURE Myrtle Palmer by Helen Olson	25. EMBALMER Robert G. Ross	LICENSE NO. E-497

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 12 1969

MAR 18 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 30 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3483
Local Reg. No. 91
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA AUG 8 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY TWIN FALLS

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE Bureau of Vital Statistics

c. LENGTH OF STAY (In this place) 13 DAYS

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDAHO

d. STREET ADDRESS (If rural, give location) ROUTE #3

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) ARTHUR c. (Last) SHAFFER

4. DATE OF DEATH (Month) (Day) (Year) AUGUST 4, 1969

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH OCTOBER 12, 1929

9. AGE (In years last birthday) 39 IF UNDER 1 YR. Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO BODY REPAIRMAN

10b. KIND OF BUSINESS OR INDUSTRY AUTO BODY SHOP

11. BIRTHPLACE (State or foreign country) ALBERT LEE, MINNESOTA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME WALTER EUBANKS BIRTHPLACE UNKNOWN

14. MOTHER'S MAIDEN NAME GRACE KELLER BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) KOREAN CONFLICT

16. SOCIAL SECURITY NO. 519-30-7659

17. INFORMANT'S OWN SIGNATURE James D. Bentley ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1929

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Glioblastoma multiforme — INTERVAL BETWEEN ONSET AND DEATH 9 months +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from JULY 22, 1969, to AUGUST 4, 1969, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE Robert C. Lewis, M.D. (Degree or title) ROBERT C. LEWIS, M.D. 597

23b. ADDRESS VA CENTER, BOISE, IDAHO

23c. DATE SIGNED 8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE Aug. 4, 1969

24c. NAME OF CEMETERY OR CREMATORY ------

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Aug. 5 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Emil Waggoner

LICENSE NO. E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 8 1969
AUG 12 1969
AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended August 15, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3484
Local Reg. No. 520
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (In this place): 57 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Convalescent 337

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4331 Hillcrest Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Anna; b. (Middle); c. (Last) Greenlee

4. DATE OF DEATH: (Month) (Day) (Year): August 5, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov 12, 1877

9. AGE (In years last birthday): 91
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress 21

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Mau
BIRTHPLACE: Switzerland

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 535-01-0955A

17. INFORMANT'S OWN SIGNATURE / ADDRESS: John F Greenlee, 4331 Hillcrest Dr., Boise, Ida

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Cerebrovascular Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-8 *,19* 69 *, to* 8-5- *,19* 69 *, that I last saw the deceased alive on* 8-5- *,19* 69 *, and that death occurred at* 7:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. H. Mason, M.D. 333

23b. ADDRESS: 808 LaCassia Dr., Boise

23c. DATE SIGNED: 8-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2

24b. DATE: Aug 5, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountain View

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-14-1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Andrew P. Dembowski

LICENSE NO.: E-527

FIRM NAME: Mountain View Funeral Home, Boise

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death) for Anna Greenlee (Name on Original Certificate) who died (Was Born or Died) on Aug 5, 1969 (Date of Event) in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	Nov 27, 1878	Nov 12, 1877
Age , #11 Birthplace	90 , Switzerland	91 , Illinois
#14 Mother Maiden Name & Birthplace	Chiestrera, Unknown	Unknown, Germany

Subscribed and sworn to before me this 15th day of August 1969

Beatrice C. Lacey

Notary Public, residing at Boise Idaho

My commission expires August 29 1969

(Seal)

Signed [signature]

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

6330 Tahoe Drive Boise Idaho 83705

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho }
County of Ada } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 15th day of August 1969

[signature]

Notary Public, residing at Boise

My commission expires Aug 29, 1972

(Seal)

Signed Richard B. Marshland

(Signature of Any Credible Person)

517 S. Latah Boise Idaho

(Street Address, City, State)

FORM DH 60-155

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 520
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 15 1969 Bureau of Vital Stat.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 57 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Convelescent

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4331 Hillcrest Dr.

3. NAME OF DECEASED (Type or Print)
a. (First): Anna
b. (Middle):
c. (Last): Greenlee

4. DATE OF DEATH (Month) (Day) (Year): Aug. 5, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 11-27-78
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Switzerland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew Mau — BIRTHPLACE: Switzerland
14. MOTHER'S MAIDEN NAME: unk. Chiestrera — BIRTHPLACE: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 535-01-0955-A
17. INFORMANT'S OWN SIGNATURE: John F Greenlee — ADDRESS: ~~4331 Hillcrest Dr.~~ Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebrovascular Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-8, 1969, *to* 8-5, 1969 *that I last saw the deceased alive on* 8-5, 1969, *and that death occurred at* 7:00 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: 808 LaCassia Dr. Boise.
23c. DATE SIGNED: 8-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: Aug 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-14-69
REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson
25. EMBALMER: Andrew P. Dembowski
LICENSE NO.: E-527
Mountain View Funeral Home, Boise

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 11 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3485
Local Reg. No. 92
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian rural
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1 Mile so. onhighway 69

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian rural
d. STREET ADDRESS (If rural, give location) Rt. 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Dale	L.	Towler	Aug. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	March 8, 1939	30				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Construction Supply Co.	Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pete Towler	Missouri	Eunice Gautney	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes		518-42-4388	Darlene Towler	Rt. 2 Meridian

8169

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH: Inst.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Public Road	Meridian	Ada	Idaho 13010

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8-5-69 1:15A m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Automobile Accident, single car

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* ____, *and that death occurred at* 1:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
553 [signature]	Coroner	3720 Meadow Drive, Boise,	8-6-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	8-8-69	Hillcrest Memorial	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 11, 1969	Myrtle Palmer	Jack J. Green	E-528

FIRM NAME Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

7. DUTIES:

AUG 1 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 28 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3486
Local Reg. No. 517
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 6 Hrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus
d. STREET ADDRESS (If rural, give location): 1820 Vista

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John		Barriatua	August 6 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Nov. 11, 1906	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Same	Nampa, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Damingo Barriatua	Spain	Teadora Baterica	Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWII	519-03-6546	X Mrs. Celina Barriatua	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hepatic and adrenal insufficiency — 7d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Undifferentiated esophageal Carcinoma — 1yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7 July 1969	Metastatic Carcinoma in liver	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Robert J. Holdren M.D.	2010 State St, Boise	12 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 11-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 11, 1969	Myrtle Palmer	Erle E. Gibson	E-533

FIRM NAME: GIBSON FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 4 1969

AUG 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 7 1973

MAY 2 5 1995

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

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STATEMENT OF USUAL RESIDENCE OF DECEASED

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

AUG 15 1969

Bureau of Vital Statistics

State File No. 3487
Local Reg. No. 521
Reg. Dist. No. 270

BIRTH NO. 343-4281

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Camas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hill City
d. STREET ADDRESS (If rural, give location): ----------

3. NAME OF DECEASED (Type or Print)
a. (First): Jesse
b. (Middle): Walker
c. (Last): Bolt

4. DATE OF DEATH (Month) (Day) (Year): Aug. 6, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 25, 1876

9. AGE (In years last birthday): 93
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Villisca, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Adam Bolt
BIRTHPLACE: Pennsylvania

14. MOTHER'S MAIDEN NAME: Susan Gourley
BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-54-0818

17. INFORMANT'S OWN SIGNATURE: X J. D. Bolt
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Bronchopneumonia - 485 X
INTERVAL BETWEEN ONSET AND DEATH: 2 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Old age -
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1969 *to* Aug. 6, 1969 *that I last saw the deceased alive on* July 28, 1969 *and that death occurred at* ? m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert Frazier (Degree or title): M.D.
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: Aug 12, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/9/1969
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Aug. 13, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Earl Waggoner
LICENSE NO.: E-422
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

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DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3488
Local Reg. No. 522
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 15 1969

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION: Boise Conv. Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print): a. (First) Lillie; b. (Middle) E.; c. (Last) Crawford

4. DATE OF DEATH (Month) (Day) (Year): Aug. 6, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 28, 1881

9. AGE (In years last birthday): 87
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lincoln, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harry Rotan
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Nellie Pell
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Kenneth E. Crawford
ADDRESS: Meridian

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) arteriosclerotic Heart Disease,

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Probable stroke - Recent Duodenal ulcer

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/14, 19 69, *to* 7/28, 19 69, *that I last saw the deceased alive on* 7/28, 19 69, *and that death occurred at* 1:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] M.D. (Degree or title)

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 8/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-8-69

24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery

24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Aug. 14, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Jack H. Green

LICENSE NO.: E-508

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED AUG 15 1969

STATE OF IDAHO

State File No. 3489
Local Reg. No. 523
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6054 Oreana Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Gertrude b. (Middle) B c. (Last) Emslie

4. DATE OF DEATH: (Month) August (Day) 6, (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1-6-79
9. AGE (In years last birthday): 90 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher-Musician
10b. KIND OF BUSINESS OR INDUSTRY: Piano
11. BIRTHPLACE (State or foreign country): Farley, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Kephart BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Margaret McGee BIRTHPLACE: Dubuque, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Margaret L King ADDRESS: 6054 Oreana Dr. Boise 83705

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Few days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* Jan 25, 1967, *to* 6 Aug 1969, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 2:00 PM m., *from the causes and on the date stated above.*

23a. SIGNATURE: Chas. Statler, M.D. (Degree or title)
23b. ADDRESS: 6003 Overland Boise, Ida.
23c. DATE SIGNED: 8 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 8/7/69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Crematory
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Aug. 14, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Clarence L. Stalkenbach
LICENSE NO.: E-527

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

DUTIES:

OCT 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended 9-10-69

Certificate of Death
STATE OF IDAHO

State File No. 3490
Local Reg. No. 516
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (In this place): 6 weeks

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Oregon
b. COUNTY: Multnomah

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Portland

d. STREET ADDRESS (If rural, give location): 6707 Southeast 106

3. NAME OF DECEASED (Type or Print): a. (First) Ethel b. (Middle) Mae c. (Last) Mark

4. DATE OF DEATH: (Month) August (Day) 6 (Year) 1969

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: August 27, 1896

9. AGE (In years last birthday): 72
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Bloomfield, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles A. Barnes
BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Susan Lewman
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 543-07-5991A

17. INFORMANT'S OWN SIGNATURE: Wilma Mitchell
ADDRESS

4367

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Disease — progressive
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 6, 1969, *to* August 6, 1969, *that I last saw the deceased alive on* August 6, 1969, *and that death occurred at* 4:05 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Donald M. Mack (Degree or title): M.D.

23b. ADDRESS: 401 North Orchard

23c. DATE SIGNED: Aug. 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: August 9, 1969

24c. NAME OF CEMETERY OR CREMATORY: Terrace View

24d. LOCATION (City, town, or county) (State): Yakima, Washington

DATE REC'D BY LOCAL REG.: Aug. 8, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Erle B. Byram

LICENSE NO.: E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed Aug 13, 1969

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Ethel Mae Mark (Name on Original Certificate) who died (Was Born or Died) on August 6, 1969 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
birthdate	August 27, 1895	August 27, 1896
Age at death	74	72

Subscribed and sworn to before me this ..... day of ....., 19.....

Notary Public, residing at .....
My commission expires .....
(Seal)

Signed Ethel B. Byram
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.
County of ..... }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 10th day of September, 1969

Ruby Hamilton

Notary Public, residing at Boise Idaho
My commission expires January 10, 1970
(Seal)

Signed [illegible]
(Signature of Any Credible Person)

(Street Address, City, State)

FORM DH 60-155

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED

SEP 10 1969

Bureau of Vital Statistics

State of ..... Certificate No. .....

County of ..... Date Filed Aug 23, 1969

The undersigned [illegible] the certificate of [illegible] (Birth or Death)

for [illegible] (Name on Original Certificate) [illegible] (Sex Born or Died) on August 6, 1969 (Date of Event)

in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Affidavit Record, Insurance Policy, Etc.) prepared on ..... (Give Date) are:

FACTS TO BE CORRECTED (Name, Date, Cause of Death, Etc.)	FROM (As of Original)	TO (The Correct Facts)
Birthdate	August 27, 1896	August 27, 1896
Age at death	74	72

Subscribed and sworn to before me this ..... day of .....

Signed [illegible]

(Signature of parent or [illegible] a birth record; [illegible] a death record, or other credible person)

Notary Public, residing at .....

My commission expires .....

(Seal) (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.

County of .....

(This Affidavit MUST Also be Executed (See Chapter 129, 1937 Idaho Session Laws.))

[illegible] that he has knowledge of the corrected facts as set forth above and that they are [illegible] knowledge.

Subscribed and sworn to before me this ..... day of .....

Signed .....

(Signature of Any Credible Person)

Notary Public, residing at .....

(Street Address, City, State)

STATE OF IDAHO LUBLIC NOTARY

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 13 1969 Bureau of Vital Statistics

State File No. 516
Local Reg. No. 370
Reg. Dist. No.
BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 6 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION: Saint Lukes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Oregon
b. COUNTY: Multnomah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Portland, Oregon
d. STREET ADDRESS (If rural, give location): 6707 Southeast 106 Portland

3. NAME OF DECEASED (Type or Print): a. (First) Ethel b. (Middle) Mae c. (Last) Mark
4. DATE OF DEATH: (Month) August (Day) 6, (Year) 1969
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: August 27, 1895
9. AGE (In years last birthday): 74
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Bloomfield, Neb
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles A. Barnes BIRTHPLACE: Neb.
14. MOTHER'S MAIDEN NAME: Susan Lewman BIRTHPLACE: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 543-07-5991A
17. INFORMANT'S OWN SIGNATURE: Thelma Mitchell ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Disease — propensie
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/6, 19 69, to 8/6, 19 69, *that I last saw the deceased alive on* 8/6, 19 69, *and that death occurred at* 4:05 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD.
23b. ADDRESS: 240 NO orchard.
23c. DATE SIGNED: 8/7/69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 9, 69
24c. NAME OF CEMETERY OR CREMATORY: Terrace View
24d. LOCATION (City, town, or county) (State): Yakima Washington

DATE REC'D BY LOCAL REG.: Aug. 8 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Erle B. Byram [signature]
LICENSE NO.: E-533
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 25 1969

SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3491
Local Reg. No. 531
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 20 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1138 E. Bannock Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LILLIAN	RAY	WOODHEAD	Aug.	6	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	May 13, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Chicago, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown		unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE
No	518-54-2033	x E. Woodhead 1138 E. Bannock St. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Gastric Hemorrhage	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Gastric ulceration	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cirrhosis of liver - severe	

5310

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-25, 1969, *to* 8-6, 1969, *that I last saw the deceased alive on* 8-5, 1969, *and that death occurred at* 2:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. C. Johnson M.D.	Boise Ida	8-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Aug. 9, '69	Cloverdale Cem.	Boise	Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 18 1969	Myrtle Palmer	Howard L. Summers	E-509

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

OCT 3 1 1969

APR 3 1970
APR 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3492
Local Reg. No. 94
Reg. Dist. No. 371

BIRTH NO.

RECEIVED AUG 20 1969

1. PLACE OF DEATH a. COUNTY ADA	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Res. 4382 ADAMS ST.	d. STREET ADDRESS (If rural, give location) 4382ADAMS ST.

3. NAME OF DECEASED (Type or Print) a. (First) WOODROW	b. (Middle) W.	c. (Last) GABBARD	4. DATE OF DEATH (Month) 6. (Day) AUG 27, 1969 (Year)		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 28, 1913	9. AGE (In years last birthday) 56	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (State or foreign country) BOONEVILLE, KENTUCKY	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME WILLIAM GABBARD	BIRTHPLACE BOONEVILLE, KENTUCKY	14. MOTHER'S MAIDEN NAME ROSE BURNS	BIRTHPLACE BOONEVILLE, KENTUCKY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Mrs Robert V. Dotson	ADDRESS		

1519

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer, Stomach Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: I Hr;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not *19* See *to* Alive *, 19____, that I last saw the deceased alive on _____ and that death occurred at* 6P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 583 (Degree or title) Coroner	23b. ADDRESS 3720 Meadow Drive, Boise.	23c. DATE SIGNED 8-15-69.	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE August 11, 1969	24c. NAME OF CEMETERY OR CREMATORY Syringa Gradens	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Aug. 18 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Conway Grant	LICENSE NO. E478

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 12 1969
JAN 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 3 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3493
Local Reg. No. 562
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bpise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
d. STREET ADDRESS (If rural, give location): Glenns Ferry

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOE		ARNOLD	August 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 17, 1899	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Fireman	Railroad	Oakland City, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oliver Arnold	unknown	Amanda	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	717-16-3865A	Thelma L. Arnold	Glenns Ferry

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5607 Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Phlebothrombosis
DUE TO (c) Post op. bowel resection

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Volvulus of Colon

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* July 29, 1969, *to* Aug 7, 1969, *that I last saw the deceased alive on* Aug 7, 1969, *and that death occurred at* A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. C. Thurow 261	MD	Boise Idaho	8-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	8/11/69	Longmont, Colorado	Longmont, Colorado

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3 1969	Myrtle Palmer	Arthur Smith	E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3494
Local Reg. No. 551
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 29 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4203 Warm Springs Ave.

3. NAME OF DECEASED (Type or Print): a. (First) CONCHITA b. (Middle) (TITA) c. (Last) SEIBOTH BROWNE
4. DATE OF DEATH (Month) (Day) (Year): August 7, 1969
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 17, 1915
9. AGE (In years last birthday): 54
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Manila P.I.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Juan Seiboth BIRTHPLACE: Franfurt, Germany
14. MOTHER'S MAIDEN NAME: Conchita Sebastia BIRTHPLACE: Spain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: James M Browne ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Ischemia 4/23
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Atherosclerosis
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 8-7-69
19b. MAJOR FINDINGS OF OPERATION: Coronary Atherosclerosis and Myocardial Infarction
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-8, 1969, to 8-7, 1969, that I last saw the deceased alive on 8-7, 1969, and that death occurred at 4:14 P m., from the causes and on the date stated above.

23a. SIGNATURE: Rodney H Neve (Degree or title) M.D.
23b. ADDRESS: 123 E. Idaho St
23c. DATE SIGNED: 8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-7-1969
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Mystle Palmer by Helen Olson
25. EMBALMER: Eldon T. Pearson
LICENSE NO.: E-512
FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM (DH-63021

APR 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3495
Local Reg. No. 518
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho c. LENGTH OF STAY (In this place) 3 weeks	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Center 332	d. STREET ADDRESS (If rural, give location) 4515 Jewel

3. NAME OF DECEASED (Type or Print)	a. (First) Helen	b. (Middle) Frances	c. (Last) Hanun	4. DATE OF DEATH (Month) August (Day) 8 (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 7, 1888	9. AGE (In years last birthday) 81	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife c1	10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (State or foreign country) New Albany, Ind	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Easley	BIRTHPLACE New Albany, Ind	14. MOTHER'S MAIDEN NAME Mildred Hill	BIRTHPLACE New Albany, Ind.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	(If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 578-32-9830	17. INFORMANT'S OWN SIGNATURE Barbara Die Henbach	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1829

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Dehydration, Arteriosclerosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Probable Ca Uterus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 0	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18, 1969, *to* Aug 8, 1969, *that I last saw the deceased alive on* Aug. 8, 1969, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Mary L Holdren MD 235 (Degree or title)	23b. ADDRESS 148 E Jefferson	23c. DATE SIGNED 8-11-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2	24b. DATE August 11, 69	24c. NAME OF CEMETERY OR CREMATORY Mountain View Funeral Home	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Aug. 11, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Erle B. Byram	LICENSE NO. E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: GIBSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3496
Local Reg. No. 542
Reg. Dist. No. 370

BIRTH NO.

AUG 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: ADA 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE — c. LENGTH OF STAY (In this place): Hours	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. ALPHONSUS HSOPITAL 005	d. STREET ADDRESS (If rural, give location): 10263 Estate Drive

3. NAME OF DECEASED (Type or Print) a. (First) RUTH b. (Middle) V. c. (Last) KAUFMAN				4. DATE OF DEATH (Month) (Day) (Year) AUGUST 8, 1969	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED	8. DATE OF BIRTH: SEPT. 20, 1912	9. AGE (In years last birthday): 56	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N.W. DIV. MANAGER 23	10b. KIND OF BUSINESS OR INDUSTRY: "THE CHILD'S WORLD"	11. BIRTHPLACE (State or foreign country): BROKEN BOW, CUSTER, NEB.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: CHARLES E. TAYLOR, BIRTHPLACE: BROKEN BOW, NEBRASKA		14. MOTHER'S MAIDEN NAME: CLARA B. DAVIS, BIRTHPLACE: BROKEN BOW, NEBRASKA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 513 10 2520	17. INFORMANT'S OWN SIGNATURE: D.E. Kaufman		ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Metastatic Sarcoma	1 year
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Breast Sarcoma	1 year
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* April 1, 1968, *to* August 8, 1969, *that I last saw the deceased alive on* August 8, 1969, *and that death occurred at* 1:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Hu. Hatten Jr. 212 (Degree or title) MD	23b. ADDRESS: 6003 Overland Boise Ida.	23c. DATE SIGNED: 15 Aug 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	24b. DATE: AUGUST 12, 1969	24c. NAME OF CEMETERY OR CREMATORY: CLOVERDALE	24d. LOCATION (City, town, or county) (State): BOISE, IDAHO
DATE REC'D BY LOCAL REG.: Aug. 22, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Conway Grant	LICENSE NO.: E478

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 1 4 1995
APR 2 4 1995

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 20 1969 Bureau of Vital Statistics

State File No. 3497
Local Reg. No. 95
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 79 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITA, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 1608 FIRST STREET SOUTH

3. NAME OF DECEASED (Type or Print): a. (First) CARL; b. (Middle) VICTOR; c. (Last) OMAN

4. DATE OF DEATH (Month) (Day) (Year): AUGUST 8, 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: DECEMBER 27, 1894

9. AGE (In years last birthday): 74

IF UNDER 1 YR. Months: — Days: —

IF UNDER 24 HRS. Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PIPEFITTER

10b. KIND OF BUSINESS OR INDUSTRY: SAME

11. BIRTHPLACE (State or foreign country): FINLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FREDRICK OMAN — BIRTHPLACE: FINLAND

14. MOTHER'S MAIDEN NAME: AMANDA JOHNSON — BIRTHPLACE: FINLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 543-10-7479

17. INFORMANT'S OWN SIGNATURE: James L. Bentley — ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

1621

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Adrenal insufficiency. — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Metastatic carcinoma. — Unknown

DUE TO (c) Bronchogenic carcinoma. — Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from MAY 21, 19 69, to AUGUST 8, 19 69, and that death occurred at 2:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): R. J. BUNGARD, M.D. 591

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 8-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/12/69

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens

24d. LOCATION (City, town, or county): Canyon

(State): Idaho

DATE REC'D BY LOCAL REG.: Aug. 15 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Roy Simpson

LICENSE NO.: E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 27 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3498
Local Reg. No. 525
Reg. Dist. No. 270

BIRTH NO.

RECEIVED
AUG 18 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 200 N. 3rd. St. Apt. #205

3. NAME OF DECEASED (Type or Print): a. (First) Theron; b. (Middle) Jackson; c. (Last) Roper

4. DATE OF DEATH: (Month) Aug. (Day) 8, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 20, 1893

9. AGE (In years last birthday): 75
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clothing Retailer

10b. KIND OF BUSINESS OR INDUSTRY: Clothing

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Roper
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Hanna Moreau
BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 518-09-4203

17. INFORMANT'S OWN SIGNATURE: Sibyl P. Roper
ADDRESS: 200 N. 3rd. St. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — ?
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1968, *to* 8 Aug, 1969, *that I last saw the deceased alive on* 8 Aug, 1969, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: M Sawer, MD (Degree or title)

23b. ADDRESS: 312 Idaho Boise

23c. DATE SIGNED: 8/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Entombment

24b. DATE: Aug. 12, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountain View

24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: Aug. 18, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Robert G. Roper

LICENSE NO.: E-497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 20 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3499
Local Reg. No. 532
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4414 Franklin Road

3. NAME OF DECEASED (Type or Print): a. (First) James Robert; b. (Middle); c. (Last) Willingham

4. DATE OF DEATH (Month) (Day) (Year): August 8, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: June 24, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): postal clerk

10b. KIND OF BUSINESS OR INDUSTRY: Postal service

11. BIRTHPLACE (State or foreign country): Hot Springs, Arkansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James R. Willingham
BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Julie Helms
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518.48 7105

17. INFORMANT'S OWN SIGNATURE: X Mrs. Quentin Howard
ADDRESS: 501 Michael Drive

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/28, 1967, *to* 8/8, 1969, *that I last saw the deceased alive on* 8/8, 1969, *and that death occurred at* 11:05P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George R. Palmer, MD

23b. ADDRESS: 171 E. Idaho

23c. DATE SIGNED: 8/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 12, 1969

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug 18 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Glenn W Beatty

LICENSE NO.: E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 20 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 15 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3500
Local Reg. No. 533
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1015½ N. Orchard Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LAVINA	M.	BALL	Aug.	9,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 8, 1890	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Alma, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Weber	Germany	Rosa Furer	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	518-09-4624	Jack O Ball	Boise, Ida. 515 S. Roosevelt

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral + peripheral Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 9, 1969, to —, 19____, *that I last saw the deceased alive on* Aug 9, 1969, *and that death occurred at* 5:05p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. E. Johnson M.D.	M.D.	Boise Ada	8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 13, '69	Morris Hill Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 18 1969	Myrtle Palmer	Howell Johnson	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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HAIR
425
Barnock

Certificate of Death

STATE OF IDAHO

State File No. 3501
Local Reg. No. 524
Reg. Dist. No. 370

RECEIVED
AUG 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Ada b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 1 day d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Alphonsus Hospital	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise d. STREET ADDRESS (If rural, give location) 1950 Wildwood

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLOYCE	C.	BIGGERS	Aug. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct. 13, 1911	57		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrican	Electrial	Sweet, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Biggers	Ill.	Minnie Cox	Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	545-10-6479	X Pauline Biggers	Boise

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary emphysema

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CO_2 narcosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
72 hrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 8/9, 19 69, and that death occurred at 9:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	425 W. Bannock	8/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/12/69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 15, 1969	Myrtle Palmer	Clyde Vassar	E535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 15 1969

APR 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, includjng the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to ahy one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
AUG 18 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3502
Local Reg. No. 526
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: St. Lukes Hospital
d. STREET ADDRESS (If rural, give location): 5805 Robertson Dr.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	R.	Mull	August 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Jan. 5, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Postal service	Civil service	Oklahoma	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Mull	Indiana	Hester Whalen	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.I	543-22-6909	Evelyn Dillard	5720 Edson St.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Electrolyte imbalance — ?
DUE TO (c) Recent perforated gastric ulcer — 48 hrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/7/69	Perforated gastric ulcer	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8/7, 1969, to 8/9, 1969, that I last saw the deceased alive on 8/9, 1969, and that death occurred at 1:42 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] Sawer MD	312 Idaho Boise	8/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/13/69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 18 1969	Myrtle Palmer	Robert H. Lee	E-497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

2

AUG 1 8 1969

SEP 1 6 1974

MAY 2 6 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended Certificate
Sept 30, 1970

RECEIVED

Certificate of Death

STATE OF IDAHO

SEP 30 1970

Bureau of Vital Statistics

State File No. 3503
Local Reg. No. 529
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 9425 Sunflower Lane

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	ROBERT	THACKER	August 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 2, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic - Idaho State	Highway Dept.	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles F. Thacker	Pettigrew, Arkansas	Ruth White	Sundance, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War II	519 09 6663	Conway Grant / Mortuary Records	

4410

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac Tamponade — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Dissecting thoracic Aortic Aneurysm
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
—		

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		Boise	Ada	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8-7, 1969, to 8-8, 1969, that I last saw the deceased alive on 8-8, 1969, and that death occurred at 4 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Johnny H. Han M.D.	123 F Idaho St.	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Aug. 11, 1969	Syringa Gardens Cmtry.	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 19, 1969	Myrtle Palmer	Conway Grant	M478

FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

AUG 19 1969

Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3503
Local Reg. No. 529
Reg. Dist. No. 270

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. ALPHONSUS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 9425 SUNFLOWER LANE

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	ROBERT	THACKER	AUGUST 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	APRIL 2, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mechanic	Idaho State Hiway Dept.	BOISE, IDAHO	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
CHARLES F. THACKER	PETTIGREW, ARKANSAS	RUTH WAITE	SUNDANCE, WYOMING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WW II	519 09 6693	Conway Grant from family records	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4410 Cardiac Tamponade

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Dissecting Thoracic Aortic Aneurysm
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-8, 1969, *to* 8-9, 1969, *that I last saw the deceased alive on* 8-8, 1969, *and that death occurred at* 7:10 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Rodney D. Dean M.D.	123 E. Idaho St.	8-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	AUGUST, 11, 1969	SYRINGA GARDENS	BOISE, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 19 1969	Myrtle Palmer	Conway Grant	E 478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 9 1969

SEP 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 14 1969 Bureau of Vital Statistics

State File No. 3504
Local Reg. No. 519
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Center 332	d. STREET ADDRESS (If rural, give location) 6523 Post St.

3. NAME OF DECEASED (Type or Print) a. (First) Minnie	b. (Middle) A.	c. (Last) Mackey	4. DATE OF DEATH (Month) (Day) (Year) Aug. 10, 1969		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 18, 1875	9. AGE (In years last birthday) 94	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Boone, N. Carolina	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-07-8146B	17. INFORMANT'S OWN SIGNATURE Mrs May Strong	ADDRESS 1		

18. CAUSE OF DEATH 4379
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	Short
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	C.V.A.	Short
DUE TO (c)	Cerebral Arteriosclerosis	Prolonged
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/1, 1959, *to* 8/10, 1969, *that I last saw the deceased alive on* _____ 19__ *and that death occurred at* 2:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 318	(Degree or title) MD	23b. ADDRESS 401 No Orchard Boise Ida	23c. DATE SIGNED 8/11/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/12/1969	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Aug. 12, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER [signature]	LICENSE NO. E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3505
Local Reg. No. 534
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 20 1969

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 719 So. Hays

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Helen	Lois	Radley	August 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	May 7, 1902	67	3	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
nurse	nursing	Troy, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
F. Henry Wallace	West Virginia	Sarah Elizabeth Parks	West Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		529-01-3115	X Rebecca D. Salyer	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Intestinal Obstruction	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Carcinomatosis of Peritoneum & Obstructive bands of Ileum	3 months
DUE TO (c)	Metastatic Ca of Ovaries	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	with Primary Ca of Breast	5 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Cancer of Breast & Metastasis as above	YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/17, 1969, *to* 8/10, 1969 *that I last saw the deceased alive on* 8/10, 1969, *and that death occurred at* 12:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Quentin Jones 267	Md.	Boise Idaho	8/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug. 13, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 18, 1969	Myrtle Palmer	Glenn W. Beatty	#E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3506
Local Reg. No. 535
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 20 1969
Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: BOISE CONVALESCENT CENTER 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 4606 DENTON

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DORA	R.	SHOCKMAN	AUGUST 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	WIDOWED	SEPT. 10, 1891	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		BERLIN, NO. DAKOTA	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
WILLIAM SIEDSCHLAG,	GERMANY	NO RECORD	GERMANY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	NO	X Howard Shockman	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4379

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral Degeneration — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Diabetis Mellitus - Pernicious Anemia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-20, 1969, *to* 8-10, 1969, *that I last saw the deceased alive on* 8-1, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C C Johnson	M.D.	Boise Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL August 3	12, 1969 TO	HERMISTON, OREGON FOR BURIAL	HERMISTON, OREGON

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 18 1969	Myrtle Palmer	Conway Grant	E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

AUG 1 8 1969

BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 3507
Local Reg. No. 527
Reg. Dist. No. 370

AUG 1 8 1969

RECEIVED

1. PLACE OF DEATH a. COUNTY Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 2 Weeks	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Home 332	d. STREET ADDRESS (If rural, give location) 642 6th Street N. Ext.

3. NAME OF DECEASED (Type or Print)	a. (First) DELLA	b. (Middle) R.	c. (Last) STOREY	4. DATE OF DEATH (Month) Aug. (Day) 11 (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH May 25, 1894	9. AGE (In years last birthday) 75	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher 12	10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Eraskine	BIRTHPLACE Scotland	14. MOTHER'S MAIDEN NAME Luella Leigh	BIRTHPLACE Scotland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO. 518-26-8078	17. INFORMANT'S OWN SIGNATURE Jimmy Storey	ADDRESS 1904 State St.		

180X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CANCER CERVIX

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* June 24, 1969, *to* Aug 11, 1969, *that I last saw the deceased alive on* Aug 11, 1969, *and that death occurred at* 12:10a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature], M.D.	23b. ADDRESS Boise, Idaho	23c. DATE SIGNED 8-14-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	24b. DATE Aug. 14, '69	24c. NAME OF CEMETERY OR CREMATORY Mtn. View Maus.	24d. LOCATION (City, town, or county) Boise Ada (State) Idaho
DATE REC'D BY LOCAL REG. Aug. 18 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Darwell D. Demaray	LICENSE NO. E-509

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED AUG 29 1969 Bureau of Vital Statistics

State File No. 3508
Local Reg. No. 553
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 8 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Lukes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3115 Sycamore Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Marguerite b. (Middle) C. c. (Last) Baird

4. DATE OF DEATH: (Month) Aug. (Day) 12, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 21, 1904

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home marker

10b. KIND OF BUSINESS OR INDUSTRY: Own

11. BIRTHPLACE (State or foreign country): Portland, Oregon

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Floyd James
BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Carrie Terry
BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-22-6122

17. INFORMANT'S OWN SIGNATURE: Keith Baird
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1508 Cancer of esophagus
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 16, 1969

19b. MAJOR FINDINGS OF OPERATION: Mass in cervical esophagus

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 14, 1969 *to* Aug 12, 1969, *that I last saw the deceased alive on* Aug 12, 1969, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) M.D. 265

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 15, 1969

24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

24d. LOCATION (City, town, or county) (State): Ontario, Oregon

DATE REC'D BY LOCAL REG.: 8-26-69

REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson

25. EMBALMER: Robert J Bertelson

LICENSE NO.: 222-Ore.

FIRM NAME: Bertelson-Lienkaemper

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

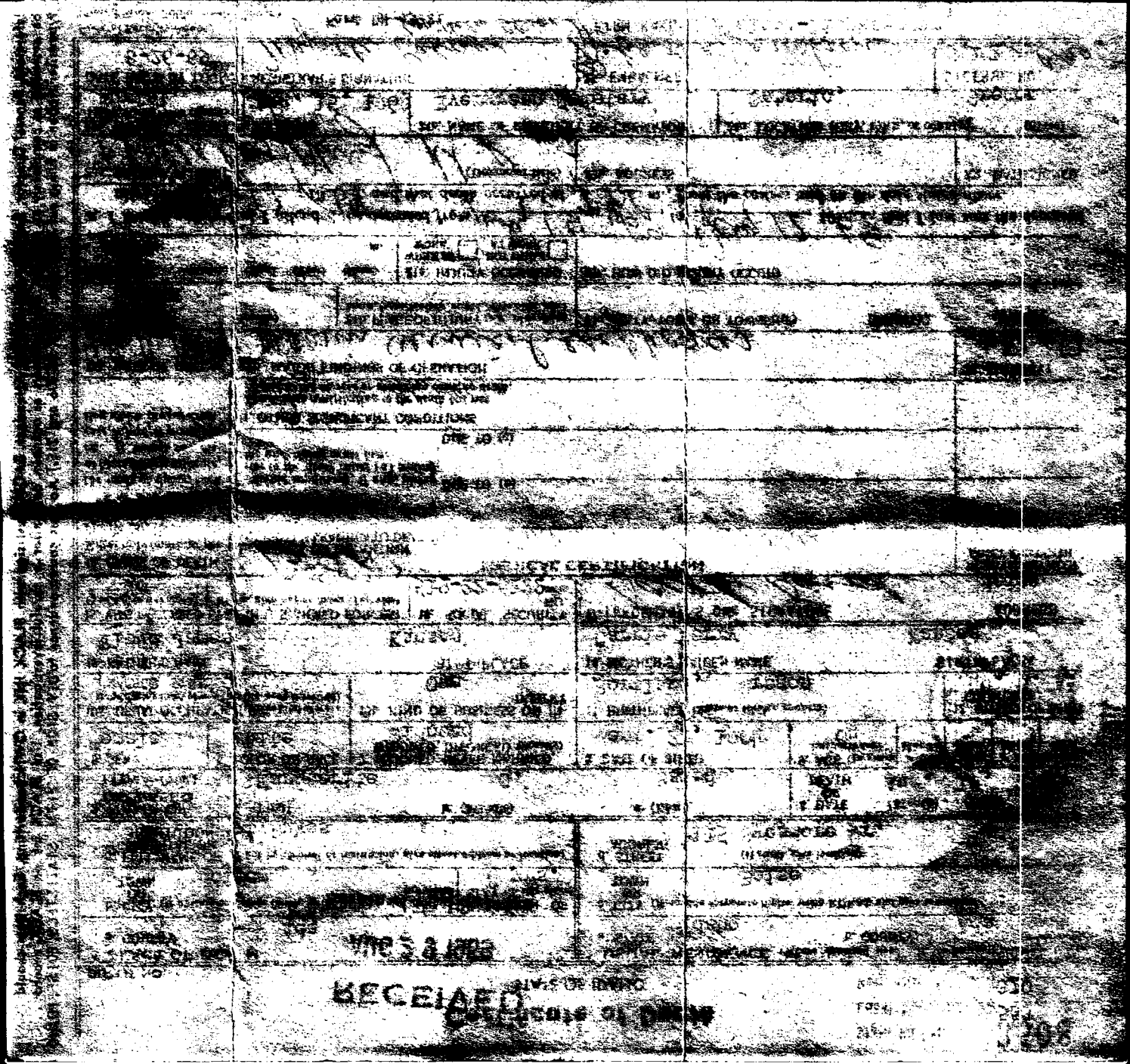
RECEIVED

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 29 1969 Bureau of Vital Statistics

State File No. 3509
Local Reg. No. 103
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada c/o
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
c. LENGTH OF STAY (In this place): 11 Years

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada c/o
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): Route #2 South Cloverdale Rd.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 2 South Cloverdale Rd. c/o

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) GREGORY c. (Last) BELGARDE

4. DATE OF DEATH: August 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Dec. 6, 1895	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Des Moines, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Belgarde	Tipton, Iowa	Kate Martin	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI		x Mrs. Ella E. Belgarde	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Recurrent Cerebral Thrombosis
DUE TO (c): Same

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Congestive Heart failure

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5/16/69	Ileo-femoral Thrombosis	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5/16, 1969, to present, 19____, that I last saw the deceased alive on 7/20, 1969, and that death occurred at 1:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert B. Montgomery M.D.	21 21 College Blvd Boise	8/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	8-16-1969	Paul Cemetery	Paul, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-27-69	Myrtle Palmer by Helen Olson	Conway Grant	E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 9 1969
OCT 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 20 1969 Bureau of Vital Statistics

State File No. 3510
Local Reg. No. 537
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 023

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3115 Sycamore Dr.

3. NAME OF DECEASED (Type or Print)
a. (First): MAUD
b. (Middle): ANTOINETTE
c. (Last): MC KEETH

4. DATE OF DEATH: (Month) Aug. (Day) 12, (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 7, 1881
9. AGE (In years last birthday): 88
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Utica, Minnesota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry T. Baker — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Susan A. Mosher — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-24-6116A
17. INFORMANT'S OWN SIGNATURE: Morris & McKeeth — ADDRESS: GrandView

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of colon — 6 mos

19a. DATE OF OPERATION: 10 Aug 69
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of colon
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9 Aug 1969 to 12 Aug 1969, that I last saw the deceased alive on 12 Aug 1969, and that death occurred at 5:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE: [illegible] (Degree or title): MD
23b. ADDRESS: 312- Idaho
23c. DATE SIGNED: 14 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/15/69
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Aug. 18 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Harry A. Cowger
LICENSE NO.: E-526
FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 20 1969 Bureau of Vital Statistics

State File No. 3511
Local Reg. No. 96
Reg. Dist. No. 371
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: ADA 01	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE c. LENGTH OF STAY (In this place): 93 DAYS	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL, BOISE, IDA. 004	d. STREET ADDRESS (If rural, give location): IDAHO STATE VETERANS HOME

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ISAAC	JAMES	ROSS	AUGUST 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	WIDOWED	MAY 5, 1901	68	-- / --	-- / --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER 04	FARMING	ROBERT LEE, TEXAS	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
ISAAC ROSS	AUSTIN, TEXAS	ELIZABETH SANDIFER	HILLSBORO, TEXAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWII X	512-26-9878	Lincoln Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) ANAPLASTIC TRANSITIONAL CELL CARCINOMA OF BLADDER. — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
JULY 2, 1969	EXTENSIVE CARCINOMA OF BLADDER	Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from MAY 12, 1969, to AUGUST 13, 1969 and that death occurred at 6:40 a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
WAYNE G. CROOKSTON, M.D. 541	VA CENTER, BOISE, IDAHO	8-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-15-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 18, 1969	Myrtle Palmer		E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3512
Local Reg. No. 1539
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 22 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 818 McKinley

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Terald	A.	Finch	August 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 4, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Accountant 09	Idaho Power	North Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George A. Finch	Canada	Mary Ann Fress	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-07-2679A	* Emily R. Finch	818 McKinley, Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 9049 Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 4½ yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 15, 1964, to Aug. 13, 1969, *that I last saw the deceased alive on* Aug 14, 1969, *and that death occurred at* 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George R Baker	MD	171 E. Idaho St	8/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1969	Dry Creek	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 20, 1969	Myrtle Palmer	Geo. A. Bowen	E 526

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Summers Funeral Home

AUG 2 7 1969

SEP 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3513
Local Reg. No. 550
Reg. Dist. No. 370

BIRTH NO.

AUG 29 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada c//
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada c//
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2723 W. Idaho

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Harold	Dean	Limbert	Aug. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct. 4, 1945	23				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ow
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tucumcari, New Mexico
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harold Limbert — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Mary Briscoe — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-52-4386
17. INFORMANT'S OWN SIGNATURE: Mrs Harold D. Limbert — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5932

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypercosmopolitic Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure
DUE TO (c) Renal Insufficiency

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-25, 1969, *to* 8-14, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Bruce Murdy MD (Degree or title) 368
23b. ADDRESS: 2429 N. Cole Rd
23c. DATE SIGNED: 8/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 18, 1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Rodney W. Dakan — LICENSE NO.: E-508
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DH-630 (Helen Olsen)

SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 30 1981

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

69-6414 RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3514
Local Reg. No. 543
Reg. Dist. No. 370

BIRTH NO.

AUG 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): Hours	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital	d. STREET ADDRESS (If rural, give location): 2701 Rose Hill

3. NAME OF DECEASED (Type or Print) a. (First): HANI	b. (Middle): MOHAMED	c. (Last): AMAN	4. DATE OF DEATH (Month) (Day) (Year): August 15, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: June 3, 1969	9. AGE (In years last birthday) IF UNDER 1 YR. Months 2 Days 12 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant	10b. KIND OF BUSINESS OR INDUSTRY: Infant	11. BIRTHPLACE (State or foreign country): Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Mohamed Aman	BIRTHPLACE: Jeddah Saudi, Arabia	14. MOTHER'S MAIDEN NAME: Caroline Fantz	BIRTHPLACE: Longview, Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: No.	17. INFORMANT'S OWN SIGNATURE: X [signature]	ADDRESS	

486X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Quick Pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c): Not Determined.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 6 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 [signature] (Degree or title) Coroner 4	23b. ADDRESS: 3720 Meadow Drive, Boise.	23c. DATE SIGNED: 8-20-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8-16-1969	24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens	24d. LOCATION (City, town, or county) (State): Boise Ada Idaho
DATE REC'D BY LOCAL REG.: Aug. 22 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Eldon T. Pearson	LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 2 2 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3515
Local Reg. No. 549
Reg. Dist. No. 370

RECEIVED
AUG 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1618 N. 27th

3. NAME OF DECEASED (Type or Print)
a. (First): Karl
b. (Middle): Marx
c. (Last): Coonrod

4. DATE OF DEATH (Month) (Day) (Year): Aug. 15, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: January 7, 1904
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months 7, Days 8 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker
10b. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (State or foreign country): Emmett, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Jefferson Coonrod — BIRTHPLACE: Ill.
14. MOTHER'S MAIDEN NAME: Hester Robbins — BIRTHPLACE: Edna, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-07-4137
17. INFORMANT'S OWN SIGNATURE: X Edna Coonrod — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1621 Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema
DUE TO (c) Nephritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Duodenal Ulcer

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/29, 1969, *to* 8/15, 1969, *that I last saw the deceased alive on* 8/15, 1969, *and that death occurred at* 7:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] Lessor
23b. ADDRESS: Boise Ida
23c. DATE SIGNED: 8/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Emmett Cemetery
24d. LOCATION (City, town, or county) (State): Emmett Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Walter F. Potter
LICENSE NO.: E445

Federal Security Agency
United States Public Health Service
Form DH-63021 Ky Helen Olson
FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR - 6 1991

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3516
Local Reg. No. 555
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
AUG 29 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Lizzie
b. (Middle): Myrtle
c. (Last): Kent

4. DATE OF DEATH (Month) 8/ (Day) 15 (Year) 1969

5. SEX: female
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH: 10/23/1916
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Clinchport, Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Worley Vanzant — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Nettie McGinness — BIRTHPLACE: Tennessee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Virginia Woods — ADDRESS: Council, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

0119

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic & acute pulmonary insufficiency

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Previous Tbc & Thoracoplasty.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Possible Candida albicans infection

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/22, 1969, *to* 8/15, 1969, *that I last saw the deceased alive on* 8/15, 1969, *and that death occurred at* ±5 12 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 095, M.D. (Degree or title)
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify): rem-burial
24b. DATE: 8/20/69
24c. NAME OF CEMETERY OR CREMATORY: Indian Valley, Cemetery
24d. LOCATION (City, town, or county) (State): Indian Valley Idaho

DATE REC'D BY LOCAL REG.: 8-27-69
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: L. Dee Thomason
LICENSE NO.: E 388

Federal Security Agency
United States Public Health Service
Form DH-63021 by Helen Olson
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3517
Local Reg. No. 97
Reg. Dist. No. 371

BIRTH NO.

RECEIVED AUG 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: A DA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: TWIN FALLS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BUHL
d. STREET ADDRESS (If rural, give location): ROUTE # 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GLEN	(NONE)	KILLIAN	AUGUST 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	APRIL 3, 1898	71	— / —	— / —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BUTCHER	MEAT PROCESSING	GLENWOOD, UTAH	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JAMES W. KILLIAN	UTAH	MINNIE JOHNSON	UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI	519-01-42-36	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: unknown.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinomatosis — unknown.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from AUGUST 14, 1969, to AUGUST 15, 1969, and that death occurred at 1:10 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
FRED B. HINE, M.D.	VA CENTER, BOISE, IDAHO	8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-19-1969	Buhl Cemetery	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 20, 1969	Myrtle Palmer	Erle E. [illegible] Beyam	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 6 1969

FEB 2 9 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3518
Local Reg. No. 546
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Ada

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (In this place): 7 yrs

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Nursing Home 337

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Payette 380

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	Fred	Mahn	August 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	May 20, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Farming	Grand Island, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ludwig Mahn	Germany	Christina Tagge	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1	518-12-2866	Charles F Mahn	Hastings Neb

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: progressive

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2-12, 1968, *to* 8-15, 1969, *that I last saw the deceased alive on* 8-15, 1969 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
MD	20/20 Orchard Boise Ida	8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 21, 1969	River Side	Payette, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-69	Myrtle Palmer by Helen Olson	John F Wilkerson	E-435

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 28 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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MINER 1333 W Jefferson

Certificate of Death

STATE OF IDAHO

State File No. 3519
Local Reg. No. 571
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 1701 Ridge Cliff

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Dorothy	D.	Porter	8	15	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Jan. 2, 1898	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	same	Spokane Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George R. Dodson	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	538-16-7824A	[signature]	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/09

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute posterior myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease 1961 (8 yrs)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept 20, 1968 to Aug 15, 1969, that I last saw the deceased alive on Aug 15, 1969, and that death occurred at 9 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul F. Miner MD	1333 W. Jefferson St Boise, Idaho	9/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 18, 69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 5 1969	Myrtle Palmer	Erle [illegible] Bryan	E-533

Federal Security Agency
United States Public Health Service FORM GH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 1969

OCT 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 20 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 20 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
AUG 29 1969
Bureau of Vital Statistics

State File No. 3520
Local Reg. No. 556
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 806 North 6th.

3. NAME OF DECEASED (Type or Print): a. (First) LUCY b. (Middle) c. (Last) ATKINSON

4. DATE OF DEATH (Month) (Day) (Year): Aug. 16, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 21, 1877

9. AGE (In years last birthday): 91
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Sutton, England

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Stephans
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Emma Hammond
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Russell Relyea
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

485X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Broncho-pneumonia.
INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized deterioration from old age. 10 years.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 25 April, 19 69, *to* 16 August, 19 69, *that I last saw the deceased alive on* 16 August, 19 69, *and that death occurred at* 9:00 pm *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Clarence E Howard MD

23b. ADDRESS: 401 Idaho St. Boise, Idaho

23c. DATE SIGNED: 8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-19-1969

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 8-27-69

REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Dean

25. EMBALMER: Elden L. Larson

LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM CDH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3521
Local Reg. No. 98
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA (04) — AUG 25 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 25 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: OREGON (38) b. COUNTY: BAKER (555)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BAKER
d. STREET ADDRESS (If rural, give location): Box 464

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: V. A. HOSPITAL, BOISE, IDAHO (04)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDWARD	NMI	JOHNSON	AUGUST 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	NEVER MARRIED	FEB. 15, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED FARMER (04)	FARMING	HEPPNER, OREGON	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JAKE JOHNSON	SWEDEN	FLORA KELLY	VA.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI 3	540-40-52-63	James Bentley	V.A. HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	UREMIA	10 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	PYELONEPHRITIS	OVER 1 YEAR
DUE TO (c)	CARCINOMA OF PROSTATE	2 YEARS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

185X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I [redacted] attended the deceased from July 23, 1969, to Aug. 17, 19 69 [redacted] on [redacted], and that death occurred at 3:40p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis, M.D. ROBERT C. LEWIS, M.D. 597	V.A. HOSPITAL, BOISE, IDAHO	8-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-20-69	Baker, Oregon	Baker, Baker Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 21, 1969	Myrtle Palmer	John F. Wilkerson	E-435

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM PH-63021

OCT 2 9 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3522
Local Reg. No. 563
Reg. Dist. No. 270

BIRTH NO.

RECEIVED SEP 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Alpine Mobile Home Court

3. NAME OF DECEASED (Type or Print): a. (First) Lottie b. (Middle) Maria c. (Last) Petersen

4. DATE OF DEATH (Month) (Day) (Year): Aug. 17, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 23, 1896

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months 5 Days 24
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Tipton, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William S. Finnley-Tipton, Missouri
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Mary L. McPherson-Tipton, Missouri
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: X Jeanette L. Flower
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 180X Squamous Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 2 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1969, to Aug 17, 1969, that I last saw the deceased alive on Aug 17, 1969, and that death occurred at 1242 p.m., from the causes and on the date stated above.

23a. SIGNATURE: C Ronald Koons 861 (Degree or title): MD
23b. ADDRESS: St Lukes Hosp
23c. DATE SIGNED: 8/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-20-1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 2, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Leonard P. Flahiff
LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3523
Local Reg. No. 559
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA SEP 3 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE

c. LENGTH OF STAY (In this place) YEARS

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) RESIDENCE

d. STREET ADDRESS (If rural, give location) 419 South 4th, Boise, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) FREDERICK b. (Middle) PAUL c. (Last) ROTH

4. DATE OF DEATH (Month) (Day) (Year) About Aug. 17, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH 7-10-07

9. AGE (In years last birthday) 62
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not physically able to work since W.W. Two

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Peter Roth
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME no record
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 05 8322

17. INFORMANT'S OWN SIGNATURE Conway Grant/Medical Records/Boise Physicians
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Cardio-Vascular Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Starvation over long period of time. Medical records show incapacitation since World War Two.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Starvation occurred as prisoner of war on Wake Island.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Did Not See to Alive, 19, that I last saw the deceased alive on, 19, and that death occurred at IOP m., from the causes and on the date stated above.

23a. SIGNATURE E. DeParis (Degree or title) Coroner

23b. ADDRESS 3720 Meadow Drive, Boise

23c. DATE SIGNED 9-2-69.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-29-69

24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens

24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 2 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Conway Grant

LICENSE NO. E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 - 1969
SEP 11 1969
SEP 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 20 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3524
Local Reg. No. 540
Reg. Dist. No. 370

BIRTH NO. 69-7649

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) DONNA b. (Middle) JEAN c. (Last) HOBBS

4. DATE OF DEATH (Month) (Day) (Year): August 18, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): nevermarried

8. DATE OF BIRTH: August 16, 1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days: 3 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Donald Earl Hobbs

BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Jean Burt

BIRTHPLACE: Emmett, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Margaret Smelcer
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7769 Cerebral Hypoxia — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 17, 1969, *to* Aug 18, 1969, *that I last saw the deceased alive on* Aug 18, 1969, *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Mad L. Bell, M.D.
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: Aug 20, 1969.

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rosedale Cemetery
24d. LOCATION (City, town, or county) (State): Payette, Idaho

DATE REC'D BY LOCAL REG.: Aug. 20 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Walter T. Potter
LICENSE NO.: E 445
FIRM NAME: The Beatty Chapel Emmett, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3525
Local Reg. No. 544
Reg. Dist. No. 370

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 AUG 25 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 39 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 120 East 41st. Street

3. NAME OF DECEASED (Type or Print)
a. (First): BERT
b. (Middle): EVERETT
c. (Last): MARTIN

4. DATE OF DEATH (Month) (Day) (Year): August 18 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 3, 1903
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Everett, Washington.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas J. Martin — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Anna Murdock — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 538-03-2732-A
17. INFORMANT'S OWN SIGNATURE: Mrs. June L. Martin — ADDRESS: 120 E. 41st Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

486X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pseudomonas pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 Wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Pulmonary Emphysema
Chronic Pulmonary Fibrosis — 4 yr

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/1, 1967, *to* 8/18, 1969, *that I last saw the deceased alive on* 8/9, 1969, *and that death occurred at* 12:08a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George R. Baker 019 MD
23b. ADDRESS:
23c. DATE SIGNED: 8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery
24d. LOCATION (City, town, or county) (State): Seattle King Washington

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson
25. EMBALMER: Gary A. Cowger
LICENSE NO.: E-526

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 30 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 29 1980

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

AUG 11 1980

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED Certificate of Death
STATE OF IDAHO

State File No. 3526
Local Reg. No. 545
Reg. Dist. No. 370

BIRTH NO.

AUG 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 005

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Main & 10th. St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edward	M.	Morris	August 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Oct. 10, 1897	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Auto Salesman 24	Automobile	New Mexico	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marion Wimmer	Missouri	Edna Swagger	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes W.W. I	519-10-0806	+ Mrs Delbert Jones	1725 Vermont Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Nephrosclerosis.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 16, 1962 *to* Aug 18, 1969, *that I last saw the deceased alive on* August 17, 1969, *and that death occurred at* 5:20A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ott Mcconnell MD	808 Belconi Dr Boise.	8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 21, 1969	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-69	Mystle Palmer by Helen Olson	Robert G. Ross	E-497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 25 1969
NOV 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED Certificate of Death
STATE OF IDAHO

State File No. 3527
Local Reg. No. 541
Reg. Dist. No. 370

BIRTH NO.

AUG 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O. A. St. Alphonsus 03

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3312 No. 33rd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ronald	Keith	Hartman	August 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 29, 1940	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheet Metal Worker //	Construction	Boise, Idaho	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gordon W. Hartman	Nebraska	Lucille H. Masoner	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes 7-1-58-9-3-58	519-34-9914	Gladys L Hartman	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Electrocution — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	School Building	Boise,	Ada	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
August 19, 1969 m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Contact with Electrical wiring

22. *I hereby certify that I attended the deceased from* DID NOT SEE ALIVE , 19 , *that I last saw the deceased alive on* , 19 , *and that death occurred at* 9:40 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ed Paris	CORONER	3720 Meadow Drive	8-21,1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 22, 1969	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 21 1969	Myrtle Palmer	John F Wilkerson	E 435

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 1 1969

AUG 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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8-25

RECEIVED Certificate of Death
STATE OF IDAHO

State File No. 3528
Local Reg. No. 101
Reg. Dist. No. 371

BIRTH NO.

AUG 29 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA (11)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 31 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL, BOISE, IDAHO (54)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: PAYETTE (38)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NEW PLYMOUTH
d. STREET ADDRESS (If rural, give location): ROUTE #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EARL	SABURO	ISHINO	AUGUST 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	ORIENTAL	MARRIED	FEBRUARY 22, 1919	50	-- / --	-- / --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER (01)	FARMING	CALIFORNIA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
HENRY T. ISHINO	JAPAN	SHIZO SANO	JAPAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Signature)	ADDRESS
YES	WWII	519-42-5843	VA HOSPITAL RECORDS, BOISE, IDAHO	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Adenocarcinoma of colon. — INTERVAL BETWEEN ONSET AND DEATH: 4 months.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
VA m.		

22. [redacted] attended the deceased from JULY 20, 19 69, to AUGUST 20, 19 69 [redacted] [redacted], and that death occurred at 7:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred B. Hine, MD 597 FRED B. HINE, M.D.	VA CENTER, BOISE, IDAHO	8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/23/1969	Emmett Cemetery	Emmett Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-69	Myrtle Palmer by Helen Olson	Keith M. Jensen	E-517

Federal Security Agency
United States Public Health Service
FORM OH-63021

FIRM NAME: SHAFFER-JENSEN Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics AUG 29 1969

State File No. 3529
Local Reg. No. 100
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: IDA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY IN THIS PLACE: 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN. HOSPITAL, BOISE, IDA

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: BINGHAM
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SPRINGFIELD
d. STREET ADDRESS (If rural, give location): BOX 4

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARK	BLAKE	PALMER	AUGUST 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	NEVER MARRIED	MARCH 20, 1921	48	---	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARM LABORER	FARMING	MORELAND, IDAHO	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
MARK PALMER	UNKNOWN	MILLIE WILSON	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE	ADDRESS
YES	WWII	518-32-4621	Myrtle Palmer	VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 492X Chronic Obstructive Pulmonary Emphysema

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Unknown.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I last attended the deceased from AUGUST 19, 1969, to AUGUST 20, 1969, that I last saw the deceased on 19, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred B. Hine M.D. FRED B. HINE, M.D.	VA CENTER, BOISE, IDAHO	8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	8/20/69	Blackfoot Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-69	Myrtle Palmer	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-630 21 Helen Olsa

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 29 1969 Bureau of Vital Statistics

State File No. 3530
Local Reg. No. 554
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 3 Mos.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2504 Grandee St. 000	d. STREET ADDRESS (If rural, give location): 2721 Lemp St.

3. NAME OF DECEASED (Type or Print)	a. (First) IDA	b. (Middle) F.	c. (Last) WARNER	4. DATE OF DEATH (Month) Aug. (Day) 20 (Year) 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Oct. 31, 1889	9. AGE (In years last birthday): 79	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher 12	10b. KIND OF BUSINESS OR INDUSTRY: Education	11. BIRTHPLACE (State or foreign country): Lamar, Missouri	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Henry Jones	BIRTHPLACE: Illinois	14. MOTHER'S MAIDEN NAME: Melissa Gentry	BIRTHPLACE: Kansas		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 519-22-4051	17. INFORMANT'S OWN SIGNATURE: Anna L. Ives	ADDRESS: 2721 Lemp St. Boise, Idaho		

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4299

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Heart attack	1 hr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	—	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Metastatic Carcinoma from uterus	1 yr.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1969, *to* death, 19____, *that I last saw the deceased alive on* Aug 18, 1969, *and that death occurred at* 6:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE: O R Blackburn 046 MD (Degree or title)	23b. ADDRESS: 800 La Cassia Dr Boise, Ida	23c. DATE SIGNED: 26 Aug 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug. 25, '69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cem.	24d. LOCATION (City, town, or county): Boise Ada (State): Idaho
DATE REC'D BY LOCAL REG.: 8-27-69	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Robert G. Ross	LICENSE NO.: E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3531
Local Reg. No. 105
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA — SEP 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF (In this place): 10 days
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: VA HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO — b. COUNTY: PAYETTE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NEW PLYMOUTH
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRANK	J.	LEWIS	AUG. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	WID.	JULY 27, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED FARMER	FARMING	McCOOK, SO. DAK.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
CHARLES LEWIS	N.Y.	EMMA L. HEATH	WISC.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI	540-26-09-31	James Bentley	V.A. HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

582X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic renal disease.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from AUGUST 13, 1969, to AUGUST 23, 1969, and that death occurred at 1:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
R. J. BUNGARD, M.D.	V. A. HOSPITAL, BOISE, IDAHO	8-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8-23-69		Payette, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 2, 1969	Myrtle Palmer		E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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27

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3532
Local Reg. No. 102
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: ADA AUG 29 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE Bureau of Vital Statistics c. LENGTH OF STAY (In this place): 18 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): V.A.HOSPITAL,BOISE,IDAHO	d. STREET ADDRESS (If rural, give location): 1208 E. WRIGHT ST.

3. NAME OF DECEASED (Type or Print) a. (First): CHARLES	b. (Middle): NMI	c. (Last): MARLATT	4. DATE OF DEATH (Month) (Day) (Year): AUG. 23, 1969	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED	8. DATE OF BIRTH: DEC. 21, 1897	9. AGE (In years last birthday): 71 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER	10b. KIND OF BUSINESS OR INDUSTRY: SAME	11. BIRTHPLACE (State or foreign country): BOISE, IDAHO	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: WILLIAM MARLATT	BIRTHPLACE: LEWISTON,IDAHO	14. MOTHER'S MAIDEN NAME: MARTHA DALY	BIRTHPLACE: KANSAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII	16. SOCIAL SECURITY NO.: 519 03 16 94A	17. INFORMANT'S OWN SIGNATURE: Stephen J. Ewing	ADDRESS: V.A.HOSPITAL RECORDS, BOISE, IDAHO	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bronchopneumonia	7 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Congestive heart failure	5 weeks
DUE TO (c)	ASHD c̄ acute myocardial infarction	5 weeks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Manic depressive psychosis.	Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. ~~I hereby certify that~~ VA attended the deceased from Aug. 5, 1969, to Aug. 23, 1969, ~~[illegible]~~ and that death occurred at 9:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE: Robert C. Lewis (Degree or title) ROBERT C. LEWIS, M.D. 597 M.D.	23b. ADDRESS: V.A.HOSPITAL,BOISE,IDAHO	23c. DATE SIGNED: 8-23-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8-27-69	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho		
DATE REC'D BY LOCAL REG.: 8-27-69	REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson	25. EMBALMER: Robert G. Ron
LICENSE NO.: E-497	FIRM NAME: Summers Funeral Home	

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
AUG 27 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3533
Local Reg. No. 547
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 3 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 005	d. STREET ADDRESS (If rural, give location): 315 North 14th Street

3. NAME OF DECEASED (Type or Print)	a. (First) VERNON	b. (Middle) LYLE	c. (Last) STEWART	4. DATE OF DEATH (Month) (Day) (Year) Aug. 23, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married	8. DATE OF BIRTH: Feb. 22, 1916	9. AGE (In years last birthday): 53; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance 06	10b. KIND OF BUSINESS OR INDUSTRY: custodial	11. BIRTHPLACE (State or foreign country): Vallantine, Montana	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Montana	14. MOTHER'S MAIDEN NAME: Margaret Jane Murphy	BIRTHPLACE: Kansas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 542-22-7930	17. INFORMANT'S OWN SIGNATURE: x Louis Nedrum	ADDRESS: 1510 Bannock St. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5329

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute massive adrenal apoplexy	2 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Three successive operations in 3 mos.	3 mos
DUE TO (c)	Chronic duodenal ulcer	years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 8/20/69	19b. MAJOR FINDINGS OF OPERATION: Total pyloric obstruction	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/19, 1969, *to* 8/23, 1969, *that I last saw the deceased alive on* 8/23, 1969, *and that death occurred at* 5:32 AM *from the causes and on the date stated above.*

23a. SIGNATURE: M D Sower 780	(Degree or title): MD	23b. ADDRESS: 312 Idaho	23c. DATE SIGNED: 8/25/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8-26-69	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: 8-27-69	REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson	25. EMBALMER: Robert G. Ross	LICENSE NO.: E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3534
Local Reg. No. 99
Reg. Dist. No. 371

BIRTH NO.

RECEIVED

AUG 28 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: ADA 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE

c. LENGTH OF STAY (In this place): 1 day

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): V.A.HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: IDAHO

b. COUNTY: ADA 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE

d. STREET ADDRESS (If rural, give location): 2203 North 18th, Boise

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RICHARD	D.	BELCHER	AUG. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	APRIL 26, 1928	41		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN 24	INSURANCE	WATERTOWN, N.Y.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
WILLIAM BELCHER	WATERTOWN, N.Y.	HELEN BISNETT	WATERTOWN, N.Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	KC 6	302 32 4407	Clarence J. Emard	V.A.HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute myocardial infarction.	3 hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease.	5+ yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I attended the deceased from 8-24, 1969, to 8-24, 1969, and that death occurred at 3:30a m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M. D.		V.A.HOSPITAL, BOISE, IDAHO	8-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 26, 1969	Cloverdale Cem.	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-69	Myrtle Palmer by Helen Olson	Conway Grant	478 E

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

FORM DH-63021

AUG 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED SEP 2 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3535
Local Reg. No. 104
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: ADA	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: ADA 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE c. LENGTH OF STAY (In this place): 17 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): STAR
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): V.A.HOSPITAL, BOISE, IDAHO 004	d. STREET ADDRESS (If rural, give location): Box 202

3. NAME OF DECEASED (Type or Print) a. (First): ARTHUR	b. (Middle): R.	c. (Last): LAMB	4. DATE OF DEATH (Month) (Day) (Year): AUG. 24, 1969		
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED	8. DATE OF BIRTH: JUNE 9, 1890	9. AGE (In years last birthday): 79	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER 04	10b. KIND OF BUSINESS OR INDUSTRY: FARMING	11. BIRTHPLACE (State or foreign country): MERIDIAN, IDAHO	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: ROMAIN LAMB	BIRTHPLACE: ILL.	14. MOTHER'S MAIDEN NAME: LOUISA PENNINGTON	BIRTHPLACE: IOWA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES	(If yes, give war or dates of service): WWI 3	16. SOCIAL SECURITY NO.: 518 56 61 82	17. INFORMANT'S OWN SIGNATURE: Glenrose H. Ewing	ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO	

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

	INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardio-respiratory failure due to chronic emphysema and cor pulmonale	7-8 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	
DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fractured right hip, Aug. 7, 1969	17 days

19a. DATE OF OPERATION: 8-12-69	19b. MAJOR FINDINGS OF OPERATION: Intertrochanteric Fracture Right Hip	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. ~~[illegible]~~ attended the deceased from AUG. 7, 1969, to AUG. 24, 1969 ~~[illegible]~~ and that death occurred at 2 a. m., from the causes and on the date stated above.

23a. SIGNATURE: W. G. CROOKSTON, M.D. (Degree or title) 597	23b. ADDRESS: V.A.HOSPITAL, BOISE, IDAHO	23c. DATE SIGNED: 8-24-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8-28-69	24c. NAME OF CEMETERY OR CREMATORY: Star Cemetery
24d. LOCATION (City, town, or county) (State): Star, Idaho		
DATE REC'D BY LOCAL REG.: Aug. 29 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 1969

SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 12 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 2 1969 Bureau of Vital Statistics

State File No. 3536
Local Reg. No. 557
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 70 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332	d. STREET ADDRESS (If rural, give location): 8700 San Anita Drive

3. NAME OF DECEASED (Type or Print) a. (First): MARY	b. (Middle): L.	c. (Last): WILLSEY	4. DATE OF DEATH (Month) (Day) (Year): Aug. 25, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: June 30, 1884	9. AGE (In years last birthday): 85; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk 08	10b. KIND OF BUSINESS OR INDUSTRY: U.S. Post Office	11. BIRTHPLACE (State or foreign country): Audrain, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Charles E. Lander	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Elizabeth Craven	BIRTHPLACE: Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 573-26-0157	17. INFORMANT'S OWN SIGNATURE: Rose M Burnham	ADDRESS: 8700 San Anita Dr. Boise, Ida.

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary heart disease	10 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	coronary arteriosclerosis	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1968, *to* death, 19____, *that I last saw the deceased alive on* Aug 19, 1969, *and that death occurred at* 2:30 AM, *from the causes and on the date stated above.*

23a. SIGNATURE: O. R. Blackburn M.D. 046 (Degree or title)	23b. ADDRESS: 800 La Cassia Dr Boise, Ida	23c. DATE SIGNED: Aug 27, 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 8-27-69	24c. NAME OF CEMETERY OR CREMATORY: Elsinore Valley Cemetery	24d. LOCATION (City, town, or county) (State): Elsinore, California
DATE REC'D BY LOCAL REG.: Sept. 2, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Howell D Demaray	LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 3537
Local Reg. No. 565
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada on SEP 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 7 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Home at 812 N. 22nd St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 812 N. 22nd St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Clara	May	McKean	Aug. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Feb. 13, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Ross	Unknown	Sadie Makinson	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-07-5957	Lester McKean	812 N. 22nd Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Not Determined.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 E. Davis	Coroner	3720 Meadow Drive, Boise.	8-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 29, 1969	Dry Creek	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 2, 1969	Myrtle Palmer	Mary C. Cowell	E 526

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 2 4 1970

JUL 8 1991

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3538
Local Reg. No. 560
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: DOA St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1409 W. State St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edith	May	Pottenger Curtis Allen	Aug. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Nov. 16, 1893	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Roseberry, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Withrow Pottenger	LaPorte, Indiana	Martha Jane McConnell	LaPorte, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-54-3672	Dwayne R. Curtis	628 E Vista Way Chico, Calif 95926

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	acute coronary thrombosis	minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	arteriosclerotic heart disease	3 yrs-
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 26 Dec, 1963, *to* 27 Aug, 1969, *that I last saw the deceased alive on* 26 Aug, 1969, *and that death occurred at* 1:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J Hugh Cathcart MD	401 Idaho St Boise Ida	2 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/30/1969	Holmes Cemetery	Donnelley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 3 1969	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 1969

FEB 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3539
Local Reg. No. 592
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6408 Post St.

3. NAME OF DECEASED (Type or Print)
a. (First): LEON
b. (Middle): A.
c. (Last): HEADRICK

4. DATE OF DEATH (Month) (Day) (Year): Aug. 27, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 17, 1886

9. AGE (In years last birthday): 82
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Jewel Co., Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John B. Headrick
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Annie L. Amos
BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-18-7585

17. INFORMANT'S OWN SIGNATURE: X Blanche Headrick
ADDRESS: Boise Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Senility —
DUE TO (c): Cerebrovascular Insuff. — months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
C Stroke.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1967 ~~19~~, to Aug 27, 1969, that I last saw the deceased alive on Aug 26, 1969, and that death occurred at 1:30 A m., from the causes and on the date stated above.

23a. SIGNATURE: Robert Draper, M.D. (Degree or title)
23b. ADDRESS: Boise
23c. DATE SIGNED: 9.8.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/30/69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise, (State): Idaho

DATE REC'D BY LOCAL REG.: Sept. 17 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters
LICENSE NO.: E-461
FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 0 9 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3540
Local Reg. No. 568
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada — SEP 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 820 Franklin St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Doris	L	Meyer	Aug. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Aug. 13, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Examiner	Small Bus. Admin.	Preston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis F. Bronson	Utah	Ida Mathina Layne	Lewiston, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	528-01-9510	†Herman A. Meyer	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 191X Brain Tumor (Recurrent)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Aug 1969	Malignant Brain Tumor	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 1969 *to* August 1969, *that I last saw the deceased alive on* 8-27 1969 *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
A. H. Waggoner MD	401 Idaho St.	9/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/30/1969	Sunset Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 5 1969	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 5 - 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED SEP 2 1969 Bureau of Vital Statistics

State File No. 3541
Local Reg. No. 558
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1501 Fort Street

3. NAME OF DECEASED (Type or Print): a. (First) Elizabeth; b. (Middle) C.; c. (Last) Winslow

4. DATE OF DEATH (Month) (Day) (Year): August 27, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: March 21, 1912

9. AGE (In years last birthday): 57
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Idaho Power

11. BIRTHPLACE (State or foreign country): Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Colburn Winslow
BIRTHPLACE: Pennsylvania

14. MOTHER'S MAIDEN NAME: Emma T. Hendricks
BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 541-01-5347

17. INFORMANT'S OWN SIGNATURE: Grace W. Marsh
ADDRESS: Portland, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive Arteriosclerotic Heart D — 4 years
DUE TO (c): Arteriosclerosis — 8 months

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Autopsy St Lukes Hosp Boise Idaho

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 6, 19__, to Aug 27, 19 69, that I last saw the deceased alive on Aug 26, 1969, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): M.D

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: Aug 30 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 29, 1969

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Sept. 2 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Robert G. Lons

LICENSE NO.: E-497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM OH-63021

SEP 2 1969
SEP 30 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3542
Local Reg. No. 106
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 001 SEP 5 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY CASSIA 160

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE

c. LENGTH OF STAY (In this place) 3 DAYS

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) OAKLEY

d. FULL NAME OF HOSPITAL OR INSTITUTION VA HOSPITAL, BOISE, IDAHO 224

d. STREET ADDRESS (If rural, give location) UNKNOWN

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JESSE	SEVERE	HUNTER	AUGUST 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	MARCH 18, 1907	62	-- / --	-- / --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED FARMER 04	FARMING	OAKLEY, IDAHO	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
EDWARD HUNTER	UTAH	DOROTHY SEVERE	UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWII	530-05-97-68	Kenneth Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebro Vascular accident. — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease with congestive failure.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I attended the deceased from AUGUST 25, 1969, to AUGUST 28, 1969, and that death occurred at 7:50p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
RAYMOND J. BUNGARD, M.D. 591	VA CENTER, BOISE, IDAHO	8-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	8-29-69		Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 2, 1969	Myrtle Palmer	A. Dale McMullen	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP -5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3543
Local Reg. No. 574
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 2 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 5120 Hill Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ellen	Christine	Barnes	Aug. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	Aug. 31, 1884	84	11	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Larned, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Moses Tall	Missouri	Josephine Reed	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-40-5493A	X Joseph B. Barnes	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: several yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Aortic stenosis several yrs; Arteriosclerotic Kidney disease several yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-29, 1965, *to* Aug 30, 1969, *that I last saw the deceased alive on* Aug 30, 1969, *and that death occurred at* 10:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul F. Miner MD.	1333 W. Jefferson St Boise, Idaho	9/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 2, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 8 1969	Myrtle Palmer	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 10 1969 Bureau of Vital Statistics

State File No. 3544
Local Reg. No. 572
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; LENGTH OF STAY (In this place): days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 023	d. STREET ADDRESS (If rural, give location): 1912 No. 15th St.

3. NAME OF DECEASED (Type or Print) a. (First): BERT	b. (Middle): A.	c. (Last): GIVENS	4. DATE OF DEATH (Month) (Day) (Year): August 30, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Nov. 29, 1969	9. AGE (In years last birthday): 87; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Painter 21	10b. KIND OF BUSINESS OR INDUSTRY: Decorating	11. BIRTHPLACE (State or foreign country): Evans, Colorado	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: J. W. Givens	BIRTHPLACE: Ohio	14. MOTHER'S MAIDEN NAME: No Record	BIRTHPLACE: No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-07-3159	17. INFORMANT'S OWN SIGNATURE: x Addie Givens	ADDRESS: Boise	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1991

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cancer - type undetermined — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on* Aug 30, 1969, *and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) M.D. 654	23b. ADDRESS: 425 W Bannock	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 3, 1969	24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery	24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho
DATE REC'D BY LOCAL REG.: Sept. 5 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Larry S Krouch	LICENSE NO.: E-447

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3545
Local Reg. No. 566
Reg. Dist. No. 270

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
SEP 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 13 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 703 North 18th Street

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: St. Lukes Hospital

3. NAME OF DECEASED (Type or Print): a. (First) HELEN; b. (Middle) M.; c. (Last) ATKINSON

4. DATE OF DEATH: (Month) Aug. (Day) 31 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Dec. 19, 1907

9. AGE (In years last birthday): 61
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music Teacher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin B. Atkinson
BIRTHPLACE: Penn.

14. MOTHER'S MAIDEN NAME: Luella Howard
BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-07-8504

17. INFORMANT'S OWN SIGNATURE: Tokyo Japan ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1830

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Disseminated Carcinoma Ovary
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8/21/69

19b. MAJOR FINDINGS OF OPERATION: Widespread intra abdominal metastasis.

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/24/69, 19__, to 8/31/69, 19__, that I last saw the deceased alive on 8/30/69, 19__, and that death occurred at 5:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE: Ronald Koons M.D. (Degree or title)

23b. ADDRESS: St Lukes Hosp

23c. DATE SIGNED: 8/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 3, 69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cem.

24d. LOCATION (City, town, or county): Boise Ada (State) Idaho

DATE REC'D BY LOCAL REG.: Sept. 2, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Gary A. Coerper

LICENSE NO.: E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3546
Local Reg. No. 570
Reg. Dist. No. 270

RECEIVED
SEP 5 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
d. STREET ADDRESS (If rural, give location): 1 mile east 1½ mile south of city

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NELLIE	FRY	WEST	August 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	January 22, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Grant City, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lorenzo B. Fry	UNK.	UNK.	UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-42-5523-B	Court West	Wendell, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia. — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic nephritis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. uremic Pericarditis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/25, 1968, *to* 8/29, 1969, *that I last saw the deceased alive on* 8/29, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Boise, Idaho	9/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	August 31, 1969	Wendell Cemetery	Wendell Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 5 1969	Myrtle Palmer	Earl Glenn B. Bryan	E-533

FIRM NAME: Gibson Funeral Home Boise, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 9 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3547
Local Reg. No. 13
Reg. Dist. No. 300

RECEIVED
AUG 28 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Council Community Hosp. 017

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Baker 035
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Halfway
d. STREET ADDRESS (If rural, give location): Pine Creek Service

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) * * c. (Last) TAYLOR

4. DATE OF DEATH (Month) (Day) (Year): August 14, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1-29-1914
9. AGE (In years last birthday): 55 IF UNDER 1 YEAR Months: 6 Days: 15 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic
10b. KIND OF BUSINESS OR INDUSTRY: self-employed
11. BIRTHPLACE (State or foreign country): Arco, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Smith Taylor BIRTHPLACE: Wyoming
14. MOTHER'S MAIDEN NAME: Margaret Scouten BIRTHPLACE: ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Muriel Taylor ADDRESS: Halfway

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 2 mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-12, 19 69, *to* 8-14, 19 69, *that I last saw the deceased alive on* 8-14, 19 69 *and that death occurred at* 9:20a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Will Cooper 8-22 M.D.
23b. ADDRESS: Council, Idaho
23c. DATE SIGNED: 8-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal
24b. DATE: 8-14-69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Crem.
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-14-69
REGISTRAR'S SIGNATURE:
25. EMBALMER: T. Dan Thomas
LICENSE NO.: E-388
FIRM NAME: Northam-Jones Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3548
Local Reg. No. 15
Reg. Dist. No. 300

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Adams 020 AUG 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Council
c. LENGTH OF STAY (In this place) few hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home at 210 N. Fairfield

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Council
d. STREET ADDRESS (If rural, give location) 210 N. Fairfield

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Wesley	Malcolm	McQuegg	August 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Jan. 27, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04	Farming	North Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William McQuegg	Canada	Unknown	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No / None	502-03-1760	x Irene R. Bunet	Council, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 11:15 PM., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold Sutton 583	Adams County Coroner	Council, Idaho	8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 19, 1969	Morris Hill Cem.	Boise, Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-23-69		Robert G. Ross	E-497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 28 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3549
Local Reg. No. 14
Reg. Dist. No. 300

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tamarack
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hiway 95

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pleasant Hill
d. STREET ADDRESS (If rural, give location): 1060 Graystone Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Susan	Jane	Weisner	8	16	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	never married	10/7/1952	16				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student	high school	Richmond, California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Carl Weisner	Sacramento, Calif.	Helen Mendelson	San Francisco Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Donna Thomason	via telephone father

8169

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Crushing Injuries of Head — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident		13020

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
8	16	1969	12:30		Car Overturning

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 12:30 Am *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Adams Co. Coroner	Council, Idaho	8/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
rem-crem.	8/19/69	Mountainview Crematory	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-23-69		D. Lee Thomason	E 388

FIRM NAME Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 28 1969 Bureau of Vital Statistics

State File No. 3550
Local Reg. No. 16
Reg. Dist. No. 300

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Meadows
c. LENGTH OF STAY (In this place) 3½ years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Meadows
d. STREET ADDRESS (If rural, give location) Box 244

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALICE	JULENE	DUNN	August 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	infant	March 4, 1966	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
infant 02		Council, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Albert Dunn	Oklahoma	Mary Alice Delp	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	Charles A Dunn	New Meadows, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

2070

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute leukemia — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) same
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-9-69, 19___, to 8-21-69, 19___, that I last saw the deceased alive on 8-21-69, 19___, and that death occurred at 10:00p m., from the causes and on the date stated above. dead

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Will A Rogue, MD	Council, Idaho	8-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug 16, 1969	Meadows Valley Cem.	Meadows, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-26-69		Burton E Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 5 1969

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 8 1969 Bureau of Vital Statistics

State File No. 3551
Local Reg. No. 288
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF CITY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 318 Hurley Lane 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Route #1, Pocatello Creek Road

3. NAME OF DECEASED (Type or Print) a. (First) HAROLD b. (Middle) G. c. (Last) LONG

4. DATE OF DEATH (Month) (Day) (Year) July 28, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH July 22, 1922
9. AGE (In years last birthday) 47
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Macon, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ernest R. Long BIRTHPLACE
14. MOTHER'S MAIDEN NAME Grace Holmes BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II 4
16. SOCIAL SECURITY NO. 518108496
17. INFORMANT'S OWN SIGNATURE Lavenna Long ADDRESS Lava Hot Spr. Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Apparent Heart Attack — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — *, 19*__*, to* — *, 19*__*, that I last saw the deceased* dead *on* 7-28-69 *, 19*__*, and that death occurred at* ? *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton H. John 583 4 (Degree or title) Coroner
23b. ADDRESS Bannock Co. Ida.
23c. DATE SIGNED 9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 1, 1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. SEP 5 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER Theron Miller
LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 8 1969

OCT 27 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 29 1969 Bureau of Vital Statistics

State File No. 3552
Local Reg. No. 271
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 429 Packard

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NORMA	JEANE	BUFFAT	August 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	Never married	Sept. 6, 1948	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary--Farm Bureau	Insurance	Co. Pocatello, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jack Buffat		Evelyn Murri	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		[signature]	Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 428X Cardiac & pulmonary failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Obscure & etiologically unknown myocardial changes.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Possible cerebral palsy (mild)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* DOA Bannock Memorial _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	1075 Pocatello	8-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 4, 1969	Restlawn Mem. Gardens	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 28 1969	[signature]	[signature]	E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 8 _ 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3553
Local Reg. No. 261
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lava Hot Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Riverside Hotel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Alta b. (Middle) McClellan c. (Last) Gummersall

4. DATE OF DEATH (Month) (Day) (Year): August 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widow	February 4, 1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own home	Colonia, Juarez, Mexico	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William McClellan	Tennessee	Jane Richardson	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		x Don L Gummersall	Boise, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wayne L. Fowler 583	Act. Coroner	Box 4835 Pocatello, Idaho	14 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/7/69	Fairview Cemetery	Soda Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 14 1969	Elona Dopita	Theodore Allen	E370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Allen Funeral Home

DUTIES:

AUG 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3554
Local Reg. No. 2739
Reg. Dist. No. 510

RECEIVED
AUG 29 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 021
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 800 Block South 4th.Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 021
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1206 South 4th.Avenue (Apt #2)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ANTONIO	ROMAN	ESCOBAR	August	5	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 13, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ice Man	Pacific Fruit Express	Zacatecas Mexico	Mexico

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roque Escobar	Mexico	Pomposa Roman	Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	*****	700-03-3162	Leeda Escobar	Pocatello, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound in head — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Suicide	So. 4th. Avenue	Pocatello	Bannock	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Aug.	5	1969	10am.		

22. *I hereby certify that I attended the deceased from* [illegible] *that I last saw the deceased alive on* Aug. 5, 19 69, *and that death occurred at* 10:00am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Acting Bannock County Coroner	Pocatello, Idaho	Aug. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 8, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 29 1969	Gloria Dorita	Jack Henderson	E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

AUG 26 1969

Bureau of Vital Statistics

State File No. 3555
Local Reg. No. 268
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Hillcrest Haven 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1071 Renee Avenue

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) c. (Last) Minshew

4. DATE OF DEATH: (Month) (Day) (Year) aug. 8, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 10, 1884

9. AGE (In years last birthday): 84
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Railroad worker

11. BIRTHPLACE (State or foreign country): Eureka, North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Vick Minshew

14. MOTHER'S MAIDEN NAME: Frances Bonne Minshew

BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Ruth K. Brown
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary neoplasm, type undetermined — INTERVAL BETWEEN ONSET AND DEATH: chronic, exact date unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 3, 19 67, *to* August 8, 19 69, *that I last saw the deceased alive on* July 16, 19 69 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] M.D.

(Degree or title): L S Call MD

23b. ADDRESS: Box 852-Pocatello, Idaho

23c. DATE SIGNED: 8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 11, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG. AUG 25 1969

REGISTRAR'S SIGNATURE: Elaine Dopita

25. EMBALMER: Theron Miller

LICENSE NO.: E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3556
Local Reg. No. 262
Reg. Dist. No. 510

BIRTH NO.

RECEIVED AUG 13 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION: 392 Los Altos Drive 000	d. STREET ADDRESS (If rural, give location): 392 Los Altos Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Irene A.	Zaccardi	Brinkmann	Aug 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	June 14, 1941	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	own home	Pocatello, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Carmie Zaccardi		Fae Dicianno Zaccardi	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		George A. Brinkmann	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac arrest	few moments
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	
DUE TO (c)	Myocardial infarction	app 1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Congenital bifid aortic valve post-operative with Starr-valve	several yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 17, 19 57 *to* present, 19____, *that I last saw the deceased alive on* August 5, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J E Comstock	MD	Box 852-Pocatello-Idaho	8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 11, 1969	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 14 1969	Gloria Dopita	Theron Miller	E-324

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3557
Local Reg. No. 266
Reg. Dist. No. 510

BIRTH NO.

RECEIVED AUG 22 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho Hotel

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 168 Jones Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Albert	L.	Hansen	Unknown 8/9or 10/69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	divorced	Jun 2,	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railroad worker	U.P. Railroad	Pocatello, Idaho	USA

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
John Hansen	Malata Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No		E. M. Hansen

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc.' It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4189

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wayne L. Lovelace SBB Act. Coroner	Box 4835 Pocatello, Idaho	14 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 16, 1969	Mountain View Cem.	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 18 1969	Gloria Dopita	Theron Miller	E-554

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

AUG 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 3558
Local Reg. No. 269
Reg. Dist. No. 510

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 05 AUG 26 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hosp. 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 05
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 745 So. 10th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	OSCAR	T	FOSS	Aug.	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 24, 1891	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendent 26
10b. KIND OF BUSINESS OR INDUSTRY: Cemetery
11. BIRTHPLACE (State or foreign country): Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Oscar Foss — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Anna — BIRTHPLACE: Norway
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-20--5126
17. INFORMANT'S OWN SIGNATURE: Mrs Muriel Foss — ADDRESS: Pocatello

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4419 Ruptured Aorta — INTERVAL BETWEEN ONSET AND DEATH: 2½ days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension 1948

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE): Pocatello Bannock Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1948 *19*____, *to* Aug 13, 19 69, *that I last saw the deceased alive on* Aug 12, 19 69, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): R. P. Foss MD
23b. ADDRESS: Pocatello
23c. DATE SIGNED: 8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: AUG 22 1969
REGISTRAR'S SIGNATURE: Gloria D Spita
25. EMBALMER: George W. Knoll — LICENSE NO.: 409
FIRM NAME: Howard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 3 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 5 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
AUG 29 1969
Bureau of Vital Statistics

State File No. 3559
Local Reg. No. 273
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello; STATE OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location): Memorial Drive

3. NAME OF DECEASED (Type or Print) a. (First): William	b. (Middle): Earl	c. (Last): Packer	4. DATE OF DEATH (Month) (Day) (Year): Aug. 15, 1969	
5. SEX: Male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: Dec. 11, 1900	9. AGE (In years last birthday): 68; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Own Service Station 22	10b. KIND OF BUSINESS OR INDUSTRY: Service Station	11. BIRTHPLACE (State or foreign country): Rexburg, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William Walter Packer	BIRTHPLACE: California	14. MOTHER'S MAIDEN NAME: Elizabeth A. Sharp	BIRTHPLACE: Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): XXXXXX	16. SOCIAL SECURITY NO.: 518-07-9831	17. INFORMANT'S OWN SIGNATURE: Della Packer	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac Arrest	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	4 days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Metastatic Carcinoma of the pancreas.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 - 11, 1969, *to* 8 - 15, 1969, *that I last saw the deceased alive on* 8 - 14, 1969, *and that death occurred at* 4 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: N Wonone 174 (Degree or title): MD	23b. ADDRESS: Kasiska Bldg.	23c. DATE SIGNED: 8-26-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug. 18, 1969	24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery	24d. LOCATION (City, town, or county) (State): Preston, Idaho
DATE REC'D BY LOCAL REG.: AUG 28 1969	REGISTRAR'S SIGNATURE: Gloria Dopita	25. EMBALMER	LICENSE NO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3560
Local Reg. No. 270
Reg. Dist. No. 510

BIRTH NO.

PECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031 AUG 26 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Memorial Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Eva	Housmann	Spackman Yardley	August 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	married	Feb. 27, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	own home	Center Creek, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew Christian Housmann	Germany	Margaretha Bauer Housmann	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXXXX	519-24-2279		

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac arrest	few moments
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Severe bullous pulmonary emphysema with secondary cor pulmonale	several years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Hypertensive cardiovascular disease with uremia, angina, and congestive heart failure	approximately 3 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
No		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from November 12, 1963, to August 15, 1969, that I last saw the deceased alive on August 14, 1969, and that death occurred at 2:35am from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J E Comstock MD	Box 852-Pocatello-Idaho	8-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 19, 1969	Mountain View Cemet.	Pocatello, Idaho

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 25 1969	Edona Dopita	Theron Miller	E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 7 1969
MAR 2 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3561
Local Reg. No. 277
Reg. Dist. No. 511

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

SEP 4 1969

Bureau of Vital

1. PLACE OF DEATH
a. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-McCammon
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hiway I-15 802

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri 26
b. COUNTY Jackson 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Independence
d. STREET ADDRESS (If rural, give location) 114 Peck

3. NAME OF DECEASED (Type or Print)
a. (First) RALPH
b. (Middle) BINGHAM
c. (Last) LUCAS

4. DATE OF DEATH (Month) (Day) (Year) Aug. 16, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 13, 1930
9. AGE (In years last birthday) 38 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Diver 10
10b. KIND OF BUSINESS OR INDUSTRY Transportation
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Omer Lucas — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Ruth Bingham — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Speaks Fun. Home — ADDRESS Indepence, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) multiple injuries from auto accident and fire — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 06.
21c. (CITY, TOWN, OR TOWNSHIP) 13030 **(COUNTY)** **(STATE)** I-15, 3 miles No. of McCammon, Bannock Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 16-69 m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR? Auto accident resulting in fire, decedent died from injuries from accident and fire.

22. *I hereby certify that I attended the deceased from* ——, 19__, *to* ——, 19__, *that I last saw the deceased* ~~alive on~~ DEAD Aug 16, 1969, *and that death occurred at* 10:25A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] Acting Coroner 883 4
23b. ADDRESS 836 E. Center Pocatello Idaho
23c. DATE SIGNED 8-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Aug. 18-69
24c. NAME OF CEMETERY OR CREMATORY Independence Cem.
24d. LOCATION (City, town, or county) (State) Independence, Missouri

DATE REC'D BY LOCAL REG. SEP 2 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER [signature]
LICENSE NO. E-292

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 13 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 4 1969 Bureau of Vital Statistics

State File No. 3562
Local Reg. No. 278
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho 13 b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019	d. STREET ADDRESS (If rural, give location) 650 North 7th

3. NAME OF DECEASED (Type or Print) a. (First) Sarah	b. (Middle)	c. (Last) Larsen	4. DATE OF DEATH (Month) (Day) (Year) Aug. 17, 1969	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec. 3, 1883	9. AGE (In years last birthday) 86 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Cove, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Davis	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Mary LeVinia Gregory	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) XXXXXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Mary S Hough	ADDRESS	

18. CAUSE OF DEATH 398X
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic Rheumatic Heart, with Chronic heart failure — INTERVAL BETWEEN ONSET AND DEATH: Yes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1951, 19__, *to* 8-17-, 1969, *that I last saw the deceased alive on* 8-17-69, 19__, *and that death occurred at* 5P *m., from the causes and on the date stated above.*

23a. SIGNATURE David C. Miller 362 (Degree or title)	23b. ADDRESS Pocatello, Idaho	23c. DATE SIGNED 8-20-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/20/69	24c. NAME OF CEMETERY OR CREMATORY McCammon Cemetery	24d. LOCATION (City, town, or county) (State) McCammon, Idaho
DATE REC'D BY LOCAL REG. SEP 3 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Theron Miller	LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3563
Local Reg. No. 279
Reg. Dist. No. 511

BIRTH NO.

RECEIVED SEP 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bannock 030	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019	d. STREET ADDRESS (If rural, give location): 650 North 7th

3. NAME OF DECEASED (Type or Print)	a. (First): Mae L.	b. (Middle): Antelope	c. (Last): Williams	4. DATE OF DEATH (Month) (Day) (Year): August 18, 1969
5. SEX: Female	6. COLOR OR RACE: Indian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: May 26, 1994	9. AGE (In years last birthday): 55 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife 01	10b. KIND OF BUSINESS OR INDUSTRY: own home	11. BIRTHPLACE (State or foreign country): Montello, Nevada	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown	BIRTHPLACE	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): XXXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS	

18. CAUSE OF DEATH 5901
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Uremia	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pyelonephritis	2 wks
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerrhosis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 8-17, 1969, *to* 8-18, 1969, *that I last saw the deceased alive on* 8-17, 1969, *and that death occurred at* 7:55a *m., from the causes and on the date stated above.*

23a. SIGNATURE: M Woran 774 (Degree or title): MD	23b. ADDRESS: Kasiska Bldg	23c. DATE SIGNED: 8-26-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug. 20, 1969	24c. NAME OF CEMETERY OR CREMATORY: Bannock Creek Cemetery	24d. LOCATION (City, town, or county) (State): Bannock Creek
DATE REC'D BY LOCAL REG.: SEP 3 1969	REGISTRAR'S SIGNATURE: Blanca Dopita	25. EMBALMER: Theron J Miller	LICENSE NO.: E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 3564
Local Reg. No. 274
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 AUG 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Own Home 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 621 Park

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lucile	Parks	Kitchen	August 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	married	March5,1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 61	own home	Cole Camp, Mo.	USA

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
Joseph Columbus	Florence Bartlett Parks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
NO XXXXXX		George H. Kitchen

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Adenocarcinoma 1977

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
69-VIII-15	Metastases to Liver (Primary NOT found).	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 11-VIII, 1969, to 18-VIII, 1969, that I last saw the deceased alive on 18-VIII, 1969, and that death occurred at 2030 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.J.Sharp,M.D. 465	5th & Center, Pocatello, Ida	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug.21,1969	Restlawn Memorial	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 28 1969	Elona Ogata	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3565
Local Reg. No. 283
Reg. Dist. No. 510

BIRTH NO. 69-7770 RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 — SEP 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Memorial Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Shawn	Joseph	Houghton	August 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	never married	August 18, 1969	3 days		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	none	Pocatello, Idaho	USA

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
Herbert Paul Houghton	Darlene Payn Houghton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE — ADDRESS
No / XXX		Herbert Paul Houghton

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

7769

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Prematurity & Respiratory distress — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Birth, 19____, *to* Death, 19____, *that I last saw the deceased alive on* 21 Aug, 19 69, *and that death occurred at* 1250 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dan Roberts MD 137	527 So 12th Ave Pocatello Idaho	27 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	august 23, 1969	Mountain View	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Gloria Dopita	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3566
Local Reg. No. 244
Reg. Dist. No. 5/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock — SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL--Inkom
LENGTH OF STAY (in this place) ----
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1 mile N. of Inkom

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 907 Dolbeer

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
VERNON	A	LESTRUD	Aug.	23	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	March 24, 1907	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipfitter 21	Ship yard	North Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Olaf Lestrud	Norway	Johanna Tuff	North Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	475-03-6571	Vernon Lestrud	Pocatello

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	4109 Coronary Occlusion, Complete	?
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* 8-23, 1969, *and that death occurred at* 7 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton Hoke	Coroner	Bannock Co. Ida	9-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Aug 26, 1969	Greenacres Mem. Pk.	Bellingham Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 4 1969	Gloria Dopita	George A. Knoph	409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 16 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3567
Local Reg. No. 2797
Reg. Dist. No. 5/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 SEP 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Rest Home 244

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 145 North 18th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MAE	INA	McLAWS	Aug. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	Widowed	May 23, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Beaver, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Robison		Mary Lovina Callister	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXXX		Mrs Don McEntire	Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic heart disease with coronary artery insufficiency and congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: several yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe degenerative osteoporosis with vertebral body collapse & secondary inanition — many yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
No		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* February, 1962, *to* August 23, 1969, *that I last saw the deceased alive on* August 23, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J E Comstock MD	Box 852-Pocatello-Idaho	8-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug.26,1969	Restlawn Mem.Gardens	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 3 1969	Blanche Donita	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 4 1969

SEP 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3568
Local Reg. No. 275
Reg. Dist. No. 511

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 — AUG 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): ---
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Comm. Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 814 No. Wilson

3. NAME OF DECEASED (Type or Print)
a. (First): CLAUDE — b. (Middle): RAYMOND — c. (Last): LATTIMER, Jr.

4. DATE OF DEATH (Month) (Day) (Year): Aug. 23 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 2, 1924
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY: Clark Lines
11. BIRTHPLACE (State or foreign country): Lander, Wyoming
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Claude R. Lattimer — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Vida Nation — BIRTHPLACE: Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 568-38-9617
17. INFORMANT'S OWN SIGNATURE: Marion Lattimer — ADDRESS: Boise, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1-2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 23, 1969, *to* Aug 23, 1969, *that I last saw the deceased alive on* Aug 23, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 067 [illegible]
23b. ADDRESS: 507 S 12th
23c. DATE SIGNED: 26 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: AUG 27 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: George W. Knopp
LICENSE NO.: 409

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3569
Local Reg. No. 282
Reg. Dist. No. 511

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
c. LENGTH OF STAY (If outside place): Transient
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: Salt Lake 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salt Lake City (Rural)
d. STREET ADDRESS (If rural, give location): 1395 Murphy Lane

3. NAME OF DECEASED (Type or Print)
a. (First): ALBERT
b. (Middle): *
c. (Last): PARKIN

4. DATE OF DEATH (Month) (Day) (Year): Aug. 24, 1969

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 30, 1890
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Fitter 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P. Railroad
11. BIRTHPLACE (State or foreign country): Willow Creek, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Parkin — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Mary Jane Barnes — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 712-05-6408
17. INFORMANT'S OWN SIGNATURE ADDRESS: Salt Lake City, Utah
Charles E. Parkin, 1764 Orchard Dr.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 23, 1969 *to* Aug 23, 1969 *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 12:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 070
23b. ADDRESS: Downey, Idaho
23c. DATE SIGNED: Aug. 25, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
24b. DATE: Aug. 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Memorial Gardens/Valley
24d. LOCATION (City, town, or county) (State): Salt Lake County, Utah

DATE REC'D BY LOCAL REG.: Aug. 25, 1969
REGISTRAR'S SIGNATURE: Ila Mae Cunningham
25. FUNERAL DIRECTOR ADDRESS: [signature] Whitton - Salt Lake City, Utah

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of J. Russell Wheeton Lic. No E-489 Salt Lake City, Ut. on 8/24/69

ADDITIONAL REMARKS by Physician

Certificate of Death

STATE OF IDAHO

State File No. 3570
Local Reg. No. 281
Reg. Dist. No. 511

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: 357 North 4th Avenue CTD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DORIS		FISHER	Aug. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Indian	Married	July 2, 1920	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home		U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jim Neaman		Minnie Thompson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Norma L. Wood	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4299

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Apparent Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from — , 19 , to — , 19 , that I last saw the deceased alive on 8-25-69, and that death occurred at 7P m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton M. John 583	Coroner	Bannock Co. Ida.	9-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 28, 1969	Bannock Creek Cemetery	Bannock Creek, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 3 1969	Gloria Dopita	Theron Spiller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3571
Local Reg. No. 396
Reg. Dist. No. 511

RECEIVED
AUG 29 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN: Lava Hot Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lava Hot Springs
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) b. (Middle) c. (Last): Estel Maine Wilson

4. DATE OF DEATH (Month) (Day) (Year): August 25, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: June 11, 1909

9. AGE (In years last birthday): 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): owner & operator

10b. KIND OF BUSINESS OR INDUSTRY: Fertilizer Plant

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Wilson
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Emma Gibbons
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 560-12-7203

17. INFORMANT'S OWN SIGNATURE: Floyd K Wilson
ADDRESS: Bancroft, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis
INTERVAL BETWEEN ONSET AND DEATH: Few min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1960, *to* July 23, 1969, *that I last saw the deceased alive on* July 23, 1969, *and that death occurred at* 12:29 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ronald Egbert 335 MD
23b. ADDRESS: Soda Springs Idaho
23c. DATE SIGNED: 8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/28/69
24c. NAME OF CEMETERY OR CREMATORY: Lava Hot Springs Cem.
24d. LOCATION (City, town, or county) (State): Lava Hot Springs, Idaho

DATE REC'D BY LOCAL REG.: AUG 28 1969
REGISTRAR'S SIGNATURE: Elona Dopita
25. EMBALMER: Theodore D Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

SEP 11 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 27 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital

State File No. 3578
Local Reg. No. 291
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Bannock — SEP 10 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lava Hot Springs
c. LENGTH OF STAY (In this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE: Idaho — b. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lava Hot Springs
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WINONA	MAXINE	HOOPER	Aug. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	married	May 7, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Morgan, Utah	U.S.A.

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
Thomas John	Mary Alice Ivie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		E. E. Hooper	Lava Hot Spgs.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5719

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 14 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May, 1967, *to* Aug, 1969, *that I last saw the deceased alive on* July 25, 1969, *and that death occurred at* 9:13 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen N. Wright, M.D.	Soda Springs, Idaho	9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 30, 1969	Lava Hot Springs Cem.	Lava Hot Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 9 1969	Gloria Dopita	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 1 2 1969

SEP 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3573
Local Reg. No. 285
Reg. Dist. No. 510

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Comm. Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 760 No. Arthur Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): HELEN
b. (Middle): NEWELL
c. (Last): CLEARE

4. DATE OF DEATH (Month) (Day) (Year): Aug. 27 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 5, 1891
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 1 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teaher 12
10b. KIND OF BUSINESS OR INDUSTRY: Education
11. BIRTHPLACE (State or foreign country): Galesburg, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Carl D. Latterner — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Margaret Mullen — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Mrs Margaret McMahon — ADDRESS: Pocatello

4369

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Generalized arteriosclerosis — several years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerotic heart disease with aortic stenosis, auricular fibrillation & congestive heart failure — several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec., 1968, *to* Aug. 27, 1969, *that I last saw the deceased alive on* Aug 27, 1969, *and that death occurred at* 4:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John B. Comstock M.D. — J E Comstock MD
23b. ADDRESS: Box 852-Pocatello-Idaho
23c. DATE SIGNED: 9-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: SEP 4 1969
REGISTRAR'S SIGNATURE: Gloria Dopeta
25. EMBALMER: George W. Knoff
LICENSE NO.: 409

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 11 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 8 1969 Bureau of Vital Statistics

State File No. 3574
Local Reg. No. 286
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello; c. LENGTH OF STAY (In this place) 1 hour	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Comm. Hosp. 019	d. STREET ADDRESS (If rural, give location) 700 E. Eldredge Rd.

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS	b. (Middle) CRAIG	c. (Last) KELLOW	4. DATE OF DEATH (Month) Aug. (Day) 28 (Year) 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Oct. 2, 1954	9. AGE (In years last birthday) 14; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03	10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) Pocatello, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack C. Kellow	BIRTHPLACE Idaho	14. MOTHER'S MAIDEN NAME Evelyn Fisher	BIRTHPLACE Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No; (If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Mrs Evelyn Kellow Dr BK	ADDRESS Pocatello	

9229

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gun-Shot Wound — INTERVAL BETWEEN ONSET AND DEATH 1½ hr.

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Trailer Lot 31	21c. (CITY, TOWN, OR TOWNSHIP) Pocatello 13031 (COUNTY) Bannock (STATE) Idaho.	
21d. TIME OF INJURY (Month) 8 (Day) 28 (Year) 69 (Hour) 5 50 A. m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Shot by Police Officer	

22. *I hereby certify that I attended the deceased from* — *, 19* — *, to* — *, 19* — *, that I ~~last~~ saw the deceased ~~alive~~ dead. on* 8-28 *, 19*69 *, and that death occurred at* 7:25 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton H. John 583	4 (Degree or title) Coroner	23b. ADDRESS Bannock Co. Idaho	23c. DATE SIGNED 9-4-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sep 2, 1969	24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.	24d. LOCATION (City, town, or county) Pocatello (State) Idaho
DATE REC'D BY LOCAL REG. SEP 4 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER George W. Knapp	LICENSE NO. 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3575
Local Reg. No. 298
Reg. Dist. No. 510

RECEIVED Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 03 SEP 8 1969
b. CITY OR TOWN Pocatello
LENGTH OF STAY (in this place) hours
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Comm. Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 03
c. CITY OR TOWN Pocatello
d. STREET ADDRESS (If rural, give location) 854 El Rancho Blvd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	R	TEGGE	Aug.	29	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Jan. 26, 1923	46				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager 26
10b. KIND OF BUSINESS OR INDUSTRY: Grocery Co.
11. BIRTHPLACE (State or foreign country): McIntosh, So. Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Randolph C. Tegge — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Philomena Mealue — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO. 518-18-0066
17. INFORMANT'S OWN SIGNATURE: Mrs Wm Tegge — ADDRESS: Pocatello

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ventricular fibrillation
DUE TO (c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gastroduodenitis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-22-, 1969, *to* _____, 19____, *that I last saw the deceased alive on* 8-22-69, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Melton Md (Degree or title) 107
23b. ADDRESS: 107 N. 5th Pocatello
23c. DATE SIGNED: 9-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Sep 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell Idaho

DATE REC'D BY LOCAL REG. SEP 5 1969
REGISTRAR'S SIGNATURE: Viola Dopita
25. EMBALMER: George W. Knopp
LICENSE NO. 409

FIRM NAME: Howard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 5 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 4 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 30 2000

APR 23 2013

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3576
Local Reg. No. 292
Reg. Dist. No. 510

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 264 Sorensen Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): HERBERT
c. (Last): LEWIS

4. DATE OF DEATH (Month) August (Day) 30 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: December 1, 1905
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman 10
10b. KIND OF BUSINESS OR INDUSTRY: Union Pacific R. R.
11. BIRTHPLACE (State or foreign country): Butler Tenneessee
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George W. Lewis — BIRTHPLACE: Butler, Tenneessee
14. MOTHER'S MAIDEN NAME: Marth E. White — BIRTHPLACE: Butler, Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: 712-03-9141
17. INFORMANT'S OWN SIGNATURE: Mrs John Lewis — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2050

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myelogenous Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967, 19__, *to* Aug. 30, 19 69, *that I last saw the deceased alive on* Aug. 30, 19 69, *and that death occurred at* 7:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David C. Miller, Md.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Sept. 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountianview Cemetery
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: SEP 8 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: # - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 11 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 20 1990

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3577
Local Reg. No. 289
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031 — SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello — LENGTH OF STAY (In this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley View Rest Home 021

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) GLEN b. (Middle) ALLEN c. (Last) POTTER

4. DATE OF DEATH (Month) (Day) (Year) August 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	married	May 24, 1908	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Farmer and Cemetery 04	Caretaker	Rockland, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John W. Potter		Martha L. Allen	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Josephine Potter	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

188X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of bladder — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cachexia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
May 7, 1968	Carcinoma of bladder	Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 1965, 19__, to ____, 19__, that I last saw the deceased alive on July 29, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
190 C D Groom, M.D.	Pocatello	Sept 3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 2, 1969	Lava Hot Springs Cemetery	Lava Hot Springs, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 5 1969	Elona Depota	Theron Miller	E-527

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 9 1969
APR 2 7 2012

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3578
Local Reg. No. 295
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 057
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 057
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 218½ South Hayes Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HEBER	CHARLES	ALLEN	August 31 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	October 10, 1881	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Utilites Comm. 08
10b. KIND OF BUSINESS OR INDUSTRY: State of Idaho
11. BIRTHPLACE (State or foreign country): Call's Fort Utah
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Heber C. Allen — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Elizaberth Iasley — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: 519-26-4979
17. INFORMANT'S OWN SIGNATURE: Mrs. D. E. Riley — ADDRESS: Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial infarction	few hours
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic heart disease	several years
DUE TO (c)	Generalized arteriosclerosis	several years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Cerebral arteriosclerosis due to generalized arteriosclerosis with senility	2 or 3 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* May 22, 1958, *to* Aug. 31, 1969, *that I last saw the deceased alive on* Aug. 31, 1969, *and that death occurred at* 5:05p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John R Comstock J E Comstock MD
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Sept. 4, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rockland Cemetery
24d. LOCATION (City, town, or county) (State): Rockland Idaho

DATE REC'D BY LOCAL REG. SEP 10 1969
REGISTRAR'S SIGNATURE: Elona Dorita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics
SEP 10 1969

State File No. 3579
Local Reg. No. 293
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1320 East Clark

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHAUNCEY	EBENEZER	BROWN	Aug. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	married	June 16, 1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
∅		Draper, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Brown	Utah	Mary Ann Hales	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		George W. Brown	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Primary carcinoma of the recto-sigmoid — 2-1/2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Large ventral hernia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3-15-67 6-20-69	As above	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb. 1967 *to* Aug. 31 1969 *that I last saw the deceased alive on* August 31, 1969 *and that death occurred at* 1:02 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Melvin M. Graves M.D.	1448 East Center Pocatello, Idaho	9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept.2,1969	Restlawn Mem.Gardens	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 8 1969	Gloria Donita	Theron J. Miller	E-524

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3580
Local Reg. No. 287
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 03 SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (in this place) 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1072 Encino

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1072 Encino

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOYCE	MARLENE	PRICE	Aug. 31 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Sept. 30, 1938	30				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Reuben Godby — BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Esther Spritzer — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mae Price — ADDRESS Pocatello

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8549

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Overdose of Sleeping Pills — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / ~~SUICIDE~~ / ~~HOMICIDE~~ (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01
21c. (CITY, TOWN, OR TOWNSHIP) Pocatello 1303 (COUNTY) Bannock (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-31-69 ? m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? See above.

22. *I hereby certify that I attended the deceased from* — *, 19__, to* — *, 19__, that I ~~last~~ saw the deceased alive on* 8-31-69 *, and that death occurred at* 8 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton Dohm 583 (Degree or title) Coroner
23b. ADDRESS Bannock Co. Hosp.
23c. DATE SIGNED 9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Sep 1, 1969
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) Gooding (State) Idaho

DATE REC'D BY LOCAL REG. SEP 4 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER George W. Ray
LICENSE NO. 409
FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3581
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dingle Idaho
c. LENGTH OF STAY (In Hospital)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dingle Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Wesley b. (Middle) Jean c. (Last) Ream

4. DATE OF DEATH (Month) (Day) (Year) Aug 2 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 27, 1915
9. AGE (In years last birthday) 54 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dingle Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME W.W. Ream — BIRTHPLACE Dingle Idaho
14. MOTHER'S MAIDEN NAME Mary Sirrine — BIRTHPLACE Dingle Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War II
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Florence S Ream — ADDRESS Dingle Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of Pancreas — INTERVAL BETWEEN ONSET AND DEATH 10 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1959, *to* July, 1969, *that I last saw the deceased alive on* July 20, 1969, *and that death occurred at* 10:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE Paul C. Haines M.D. (Degree or title) 126
23b. ADDRESS Montpelier Ida
23c. DATE SIGNED 8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 5 1969
24c. NAME OF CEMETERY OR CREMATORY Dingle Ream
24d. LOCATION (City, town, or county) (State) Dingle Idaho

DATE REC'D BY LOCAL REG. 8-4-69
REGISTRAR'S SIGNATURE Ruby Gortcinsky
25. EMBALMER Tyle Matthews — LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3582

Local Reg. No.

Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bear Lake 040 — AUG 26 1969

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier

c. LENGTH OF STAY (in this place): Bureau of Vital Statistics

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE: Idaho

b. COUNTY: Bear Lake 040

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paris

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)

a. (First): Eva

b. (Middle): Mary

c. (Last): Thornock

4. DATE OF DEATH (Month) (Day) (Year): Aug. 13, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: May 17, 1920

9. AGE (In years last birthday): 49

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bloomington, Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: David E. Thornock — BIRTHPLACE: Bloomington Ida.

14. MOTHER'S MAIDEN NAME: Sarah Quinten — BIRTHPLACE: Bloomington Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 4199

17. INFORMANT'S OWN SIGNATURE: Nettie Thornock — ADDRESS: Paris Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hours.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes Mellitus — 2 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-18-69 19__, *to* 8-13, 1969, *that I last saw the deceased alive on* 8-13, 19 69 *and that death occurred at* 4:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.

23b. ADDRESS: 456 Main - Montpelier

23c. DATE SIGNED: 8/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 16, 1969

24c. NAME OF CEMETERY OR CREMATORY: Bloomington Cemetery

24d. LOCATION (City, town, or county) (State): Bloomington Idaho

DATE REC'D BY LOCAL REG.: 8/23/69

REGISTRAR'S SIGNATURE: Ruby Goticinsky

25. EMBALMER: Nile Matthews — LICENSE NO.: E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept 16, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3583
Local Reg. No. 36
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 052
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY (In this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Community Hospital 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harrison
d. STREET ADDRESS (If rural, give location): P. O. Box 186

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Donald	Davidson	Foster	August 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct 13, 1895	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Rapid Park, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Willard S. Foster	Unk	Mary Ellen Wood	Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes / W.W. 1 3	531-16-9898	Mrs. Rose Foster	Harrison, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Vascular Accident	6 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	unknown
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hypertension	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 25 July, 1969, *to* 1 Aug, 1969, *that I last saw the deceased alive on* 31 July, 1969, *and that death occurred at* 7:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. D. Thurston, M.D. 533	St. Maries, Idaho	1 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 4, 1969	Harrison	Harrison, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 5, 1969	Donna Brown	Gerald Browning	E 411

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Browning Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho
County of Benewah } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Donald Davidson Foster (Name on Original Certificate) who died (Was Born or Died) on Aug 1, 1969 (Date of Event)
in St. Maries, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#11 Birthplace	Michigan	Rapid Park, Minnesota

Subscribed and sworn to before me this 12 th day of September, 1969

J. W. Christensen
Notary Public, residing at St. Maries Ida.
My commission expires 6-29-71
(Seal)

Signed Gerald E. Brauneis
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

138 So. 8th, St. Maries Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Benewah } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 12 th day of September, 1969

J. W. Christensen
Notary Public, residing at St. Maries Ida.
My commission expires 6-29-71
(Seal)

Signed Miriam Stephens
(Signature of Any Credible Person)

St. Maries Ida.
(Street Address, City, State)

FORM DH 60-155

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 36
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Benewah — AUG 7 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY (in this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Comm. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harrison
d. STREET ADDRESS (If rural, give location): P.O. Box 186

3. NAME OF DECEASED (Type or Print): a. (First) Donald — b. (Middle) Davidson — c. (Last) Foster

4. DATE OF DEATH: (Month) Aug. (Day) 1 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 13, 1895

9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Willard S. Foster — BIRTHPLACE: Unk.

14. MOTHER'S MAIDEN NAME: Mary Ellen Wood — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.: 531-16-9898

17. INFORMANT'S OWN SIGNATURE: Mrs. Rose Foster — ADDRESS: Harrison Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerosis — Unknown

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Hypertension

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 July, 1969, to 1 Aug, 1969, *that I last saw the deceased alive on* 31 July, 1969, *and that death occurred at* 7:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: W.D. Thurston (Degree or title): MD

23b. ADDRESS: St. Maries, Idaho

23c. DATE SIGNED: 1 Aug. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 4, 1969

24c. NAME OF CEMETERY OR CREMATORY: Harrison

24d. LOCATION (City, town, or county) (State): Harrison Idaho

DATE REC'D BY LOCAL REG.: Aug. 5, 1969

REGISTRAR'S SIGNATURE: Donna Brown

25. EMBALMER: Gerald Browning — LICENSE NO.: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 23 1997

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept 3, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3584
Local Reg. No. 39
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries, Rural
c. LENGTH OF STAY (In this place): Few Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION: Hidden Lake Dock Area 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6718 Fairfield Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Jay; b. (Middle) Coleman; c. (Last) Smith
4. DATE OF DEATH: (Month) August (Day) 2, (Year) 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: April 15, 1939
9. AGE (In years last birthday): 30 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer 054
10b. KIND OF BUSINESS OR INDUSTRY: Idaho Power
11. BIRTHPLACE (State or foreign country): Provo, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Virgil J. Smith BIRTHPLACE: Lehi, Utah
14. MOTHER'S MAIDEN NAME: Aline Coleman BIRTHPLACE: Provo, Utah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Marine Corps. Reserve
16. SOCIAL SECURITY NO.: 519-40-7409
17. INFORMANT'S OWN SIGNATURE: Virgil J. Smith, ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Asphyxiation due to drowning — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Hidden Lake 18
21c. (CITY, TOWN, OR TOWNSHIP) St. Maries 1300 (COUNTY) Benewah (STATE) Idaho
21d. TIME OF INJURY (Month) Aug (Day) 2, (Year) 1969 (Hour) 9:30 p m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Drowned while swimming

22. I hereby certify that I attended the deceased from DOA, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 9:30p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): B. A. Rapp, M.D. 428
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 8-13-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8-4-69
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county): Boise Ada (State): Idaho
DATE REC'D BY LOCAL REG.: Aug 15, 1969
REGISTRAR'S SIGNATURE: Donna Brown
25. EMBALMER: Gerald Browning
LICENSE NO.: E-411

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
SEP 2 1969
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed Sug 15, 1969

The undersigned does solemnly swear that certain facts in the certificate of death (Birth or Death)

for Jay Coleman Smith (Name on Original Certificate) who died (Was Born or Died) on August 2, 1969 (Date of Event)

in St. Maries, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
place of burial	Morris Hill Cemetery	Dry Creek Cemetary

Subscribed and sworn to before me this 22d day of August, 1969

Notary Public, residing at Boise, Idaho

My commission expires 2-29-72

(Seal)

X Signed Virgil L. Smith
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

.....
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 2 day of September, 1969

Notary Public, residing at Eagle, Idaho

My commission expires Sept 28 1972

(Seal)

X Signed Conway Grant
(Signature of Any Credible Person)

318 No. Latah, Boise, Idaho
(Street Address, City, State)

FORM DH 60-155

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss. Certificate No. .....

County of ..... } Date Filed Sep 15, 1969

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for Jay Colmer Smith (Name on Original Certificate) who died (Was Born or Died) on August 2, 1969 (Date of Event)

in Ch. Carries, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the

true facts are shown by ..... (Bible, Record, Insurance Policy, Etc.) prepared on ..... (Give Date) are:

FACTS TO BE CORRECTED ("Name", "Birth Date", "Cause of Death", etc.)	FROM (As on Original)	TO (The Correct Facts)
Place of Burial	Norris Hill Cemetery	Dry Creek Cemetery

Subscribed and sworn to before me this ..... day of .....

Signed ..... (Signature of person or attendant if correcting a birth record; of attendant, Funeral director, informant if correcting a death record; or other credible person)

Notary Public, residing at .....

My commission expires .....

(Seal) ..... (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss. [This Affidavit MUST Also be Executed. (See Chapter 134, 1957 Idaho Session Laws)]

County of .....

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this ..... day of ..... 19 .....

Signed ..... (Signature of Any Credible Person)

Notary Public, residing at .....

My commission expires .....

(Seal) ..... Street Address, City, State

FORM OH 60-155

Certificate of Death

STATE OF IDAHO

State File No. _____
Local Reg. No. 39
Reg. Dist. No. 130

BIRTH NO.

RECEIVED AUG 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries -Rural
c. LENGTH OF STAY (In this place): Few Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hidden Lake Dock Area

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6718 Fairfield Ave

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAY	COLEMAN	SMITH	August 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	April 15, 1939	30		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lawyer Lawyer	Idaho Power	Provo, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Virgil J. Smith	Lehi, Utah	Alipe Coleman	Provo, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes Marine Corps. Reserve	519-40-7409	Virgil J. Smith	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Asphyxiation due to drowning — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about (home, farm, factory, street, office bldg., etc.))	21c. CITY, TOWN, OR TOWNSHIP	(COUNTY)	(STATE)
Accident	Hidden Lake	St. Maries	Benewah	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
8 - 2 - 69 9:30 P m.		Drowned while swimming

22. *I hereby certify that I attended the deceased from* DOA, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 9:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B. A. Rapp M.D.	St. Maries, Idaho	8-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Removal	8-4-69	Morris Hill Cemetery	Boise	Ada / Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 15, 1969	Donna Brown	Gerald Browning	E-411

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH--63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 2 1 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3585
Local Reg. No. 38
Reg. Dist. No. 130

RECEIVED
AUG 1 8 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY (in this place): 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Comm. Hosp. 034

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries 050
d. STREET ADDRESS (If rural, give location): 1522 Main Ave

3. NAME OF DECEASED (Type or Print)
a. (First): Chester
b. (Middle): Louis
c. (Last): Gaskill

4. DATE OF DEATH (Month) (Day) (Year): Aug. 3 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Sept. 12, 1883
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 17
10b. KIND OF BUSINESS OR INDUSTRY: Woods Work
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Newton Gaskill — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Evelyn Bird — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-05-1715
17. INFORMANT'S OWN SIGNATURE: Mrs Kay Nelson — ADDRESS: 224-6th City

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of the lip — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1966, *to* 8-3, 1969, *that I last saw the deceased alive on* 8-3, 1969, *and that death occurred at* 5 45/A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B. A. Rapp 428 M.D.
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: Aug. 12, 1969
REGISTRAR'S SIGNATURE: Donna Brown
25. EMBALMER: Gerald Browning — LICENSE NO.: E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 18 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3586
Local Reg. No. 40
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewa (050)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) 30 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home (STR)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah (050)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) 330 9th St.

3. NAME OF DECEASED (Type or Print)
a. (First) Edwin
b. (Middle) James
c. (Last) Beaton

4. DATE OF DEATH (Month) (Day) (Year) Aug. 4 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH May 27, 1890

9. AGE (In years last birthday) 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PEACE Officer

10b. KIND OF BUSINESS OR INDUSTRY Sheriff Law Enforcement

11. BIRTHPLACE (State or foreign country) New West Minister, B.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME no data
BIRTHPLACE

14. MOTHER'S MAIDEN NAME no data
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO. 518-34-5104

17. INFORMANT'S OWN SIGNATURE Robert M. Bates
ADDRESS St. Maries Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE B. A. Rapp (420) (Degree or title) M.D.

23b. ADDRESS St. Maries, Idaho

23c. DATE SIGNED 8-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 9, 1969

24c. NAME OF CEMETERY OR CREMATORY Woodlawn

24d. LOCATION (City, town, or county) St. Maries (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 15, 1969

REGISTRAR'S SIGNATURE Donna Brown

25. EMBALMER Gerald Browning

LICENSE NO. E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3587
Local Reg. No. 41
Reg. Dist. No. 130

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-St. Maries
c. LENGTH OF STAY (in this place): Few Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3 mi. North on 95A

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): 1546 Center Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DARREL	EMERY	HARRIS	Aug. 30 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	MAY 30, 1945	24				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Lumber	Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
CLARENCE E. Harris	Illinois	Vera A. Buckland	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Vietnam 1969	518-50-5034	Kathleen Harris	St. Maries, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fract. dislocation cervical — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Spine
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	3 mi. north 95A	St. Maries, Benewah, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8 - 30 - 69 12:15 A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Car accident

22. *I hereby certify that I attended the deceased from* DOA, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 12:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. A. Rapp M.D.	St. Maries, Idaho	9-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 3, 1969	Woodlawn	St. Maries Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 2, 1969	Donna Brown	Gerald E. Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 24 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 3588
Local Reg. No. 104
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham — AUG 25 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Springfield)
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION: American Falls Reservoir

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
d. STREET ADDRESS (If rural, give location): Fort Hall Reservation

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GLORIA	IRENE	TENDOY	Found July 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	Indian	never married	January 10, 1939	30		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Fort Hall, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Tendoy Jr.	Lemhi, Idaho	Irene Lewis	Ft. Hall, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			Agency Records	

8169

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): car missed bridge + ended
DUE TO (c): upside down in river

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	18	13000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 13, 1969, *to* [redacted], *that I last saw the deceased alive* [redacted], *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	4 (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl Story 553	Coroner	Blackfoot, Idaho	8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 28 1969	Good Shepherd Cemetery	Fort Hall, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 22 1969	Dorothy J. Jones	Alan Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3589
Local Reg. No. 105
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	ETHEL		CHRISTENSEN

4. DATE OF DEATH: (Month) Aug. (Day) 2, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Widowed	May 1, 1886	83	3	1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Salem, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Snow	Utah	Lydia Bingham	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-60-2196	Floyd L. Christensen	Blackfoot, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pyogenic Cholecystitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Congestive heart Failure — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1965 *to* Aug 2, 1969, *that I last saw the deceased alive on* Aug 2, 1969 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	8-5-69	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 21, 1969	Dorothy J. Jones	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 2 5 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3590
Local Reg. No. 106
Reg. Dist. No. 600

BIRTH NO.

AUG 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 34yr6mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Firth
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HELGE	FRITZ	HJELM	August 9 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	17 Dec. 1893	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 54		Sweden	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alexander Hjelm	Sweden	Albertina Bloomquist	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518 60 6174 T	Mary Payne	Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pulmonary Embolism and Arteriosclerotic Heart Disease	Sudden
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Chronic Debility - Due to Severe Urinary Abscess	3 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 25 July, 1966, *to* 9 Aug., 19 69, *that I last saw the deceased alive on* 9 Aug., 19 69, *and that death occurred at* 12:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D. 594	State Hospital South-Blackfoot, Idaho	11 Aug. 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-12-69	Hill Crest	Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
22 Aug 69	Dorothy J. Jones	Gary L. Walder	E 444

FIRM NAME: Walder's Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3591
Local Reg. No. 107
Reg. Dist. No. 660

BIRTH NO.

AUG 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot, Idaho
c. LENGTH OF STAY (in this place): 10 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Fort Hall
d. STREET ADDRESS (If rural, give location): Fort Hall

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Gretta		George	Aug. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Am. Indian	Divorced	April 14 1935	34	3	26		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Fort Hall, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter George	Fort Hall, Idaho	Minnie K. Racehorse	Fort Hall, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	none	Minnie K. Snipe	Blackfoot Box 177

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Irreversible Shock	2 hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Lack of blood Coagulability	Same
DUE TO (c)	Cirrhosis of Liver Severe	Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Acute Gangrenous Appendicitis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8 Aug. 69	Severe Gallbladder & Liver disease	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
9 Aug. 69		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 8, 1969, *to* 10 Aug, 1969, *that I last saw the deceased alive on* 10 Aug, 1969, *and that death occurred at* 6:45 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. Dean Packer M.D. 403	625 W. Pacific, Blackfoot	8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-14-69	Sand Hill Cemetery	Fort Hall Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 19 1969	Dorothy J. Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
BIRTH NO. AUG 25 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3592
Local Reg. No. 108
Reg. Dist. No. 600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. County: Bingham 001
b. City or Town (If outside corporate limits, write RURAL and give township): Blackfoot
c. Length of Stay (in this place):
d. Full Name of Hospital or Institution (If not in hospital or institution, give street address or location): Ash & Judicial Streets 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. State: Idaho
b. County: Bingham 060
c. City or Town (If outside corporate limits, write RURAL and give township): Rural Blackfoot
d. Street Address (If rural, give location): Rt. #2, Box 253 (Thomas)

3. NAME OF DECEASED (Type or Print): a. (First) Carl b. (Middle) J. c. (Last) Anderson

4. DATE OF DEATH: (Month) Aug. (Day) 12, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec. 6, 1889

9. AGE (In years last birthday): 79
If under 1 year: Months 8 Days 6
If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & ditchrider

10b. KIND OF BUSINESS OR INDUSTRY: Irrig. Dist. #36

11. BIRTHPLACE (State or foreign country): Holliday, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Anders Anderson
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Ingrid Neilson
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-12-2525

17. INFORMANT'S OWN SIGNATURE: Marie L. Anderson
ADDRESS: Blackfoot, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: few minute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 12, 1969 *to* Aug 12, 1969, *that I last saw the deceased alive on* Aug 12, 1969, *and that death occurred at* 11:10 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: 8-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-16-69
24c. NAME OF CEMETERY OR CREMATORY: Riverside-Thomas Cem.
24d. LOCATION (City, town, or county) (State): Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.: AUG 19 1969
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Howard Packham
LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

MAY 2 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG 25 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3593
Local Reg. No. 109
Reg. Dist. No. 60-1

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Firth
c. LENGTH OF STAY (in this place): 10 min's.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): In Grain Field Rt. #1 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Firth
d. STREET ADDRESS (If rural, give location): Firth Rt. #1

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) Phillip c. (Last) Jensen

4. DATE OF DEATH: (Month) (Day) (Year): August 15, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Nov. 17, 1888

9. AGE (In years last birthday): 80 IF UNDER 1 YEAR Months: 8 Days: 28 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Hyrum, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Alfred Jensen BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Gunilda Olive Hansen BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 529-26-2799

17. INFORMANT'S OWN SIGNATURE: Virgil Jensen ADDRESS: Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4199

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see him alive, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 5:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Kenneth Clarke 533 (Degree or title): Acting Coroner

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-19-69

24c. NAME OF CEMETERY OR CREMATORY: Firth Cemetery

24d. LOCATION (City, town, or county) (State): Firth, Bingham, Idaho

DATE REC'D BY LOCAL REG.: AUG 19 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Howard Packham LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form OH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 24 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3594
Local Reg. No. 111
Reg. Dist. No. 600

BIRTH NO. 69-5521

RECEIVED AUG 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 383 Alder St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 383 Alder St.

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle) Raymond
c. (Last) Bercier Jr.

4. DATE OF DEATH (Month) (Day) (Year) August 17, 1969

5. SEX Male

6. COLOR OR RACE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH June 20, 1969

9. AGE (In years last birthday) IF UNDER 1 YR. Months 1 Days 27 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Bercier BIRTHPLACE N. Dakota

14. MOTHER'S MAIDEN NAME Vicki Engavo BIRTHPLACE Ft. Washakie, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE George Bercier ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2559

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Sudden Death Syndrome — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adrenal insufficiency
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 17, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Carl Staley 583 (Degree or title) Coroner

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED Aug. 20, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 19, 69

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) (State) Blackfoot, Idaho

DATE REC'D BY LOCAL REG. AUG 22 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Dean Hill

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 25 1969 Bureau of Vital Statistics

State File No. 3595
Local Reg. No. 9785
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bingham 061	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot; c. LENGTH OF STAY (In this place) 1 week	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot,
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029	d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First) Vernon	b. (Middle) Wilford	c. (Last) Jensen	4. DATE OF DEATH (Month) (Day) (Year) August 17, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH January 25, 1909	9. AGE (In years last birthday) 60 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dam Tender 05	10b. KIND OF BUSINESS OR INDUSTRY Burea Indian Aff.	11. BIRTHPLACE (State or foreign country) Mapleton, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hyrum Jensen	BIRTHPLACE Spanish Fork, Utah	14. MOTHER'S MAIDEN NAME Christina Holm	BIRTHPLACE Lakeshore, Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-01-6847	17. INFORMANT'S OWN SIGNATURE Lenore E Jensen	ADDRESS Blackfoot, Idaho	

18. CAUSE OF DEATH 492X
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Emphysema	10 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cardiac decompensation	6 weeks
	Polycythemia	1 yr

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1, 1959, *to* August 17, 1969, *that I last saw the deceased alive on* August 17, 1969, *and that death occurred at* 11:40a. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 404	(Degree or title) M.D.	23b. ADDRESS Blackfoot, Idaho	23c. DATE SIGNED August 20,69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 21, 69	24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery	24d. LOCATION (City, town, or county) (State) Blackfoot, Idaho
DATE REC'D BY LOCAL REG. AUG 22 1969	REGISTRAR'S SIGNATURE Dorothy J Jones	25. EMBALMER Dean Hill	LICENSE NO. E-466

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 27 1969
JUL 20 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3596
Local Reg. No. 117
Reg. Dist. No. 600

BIRTH NO.

SEP 15 1969

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 252 Elm St.

3. NAME OF DECEASED (Type or Print): a. (First) CONNIE b. (Middle) DELORES c. (Last) TAYLOR WHITE

4. DATE OF DEATH (Month) (Day) (Year): August 20, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: August 22, 1934

9. AGE (In years last birthday): 34
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fay Taylor
BIRTHPLACE: Blackfoot, Idaho

14. MOTHER'S MAIDEN NAME: Mabel Clark
BIRTHPLACE: Blackfoot, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 529-38-4943

17. INFORMANT'S OWN SIGNATURE: Lucy E. White
ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 486X ACUTE PULMONARY EDEMA — 12 HRS

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) PNEUMONIA — 2 DAYS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Aug, 1969, to August 20, 1969, that I last saw the deceased alive on August 20, 1969, and that death occurred at 8:30p m., from the causes and on the date stated above.

23a. SIGNATURE: Gary K. Haddock 401 (Degree or title) M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: August 22, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 25, 1969

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: Sept. 11, 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: C. Dean Hill

LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 17 1969

DEC 28 1979

JUL 12 2012

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3597
Local Reg. No. 112
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061 SEP 9 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Bingham county nursingHome 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location) Route 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HAROLD	GEORGE		August 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	Indian	married		about 88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Ft. Hall, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Billy George	Unknown	Wetoestse	unknown unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-60-2041 J none	Lucy George	Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	1 MONTH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE	5 MONTHS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 25 July, 1969, to August 21, 1969, that I last saw the deceased alive on August 21, 1969, and that death occurred at 8:30a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gary F. Haddock 901 M.D.	Blackfoot, Idaho	Aug 22, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	August 25, 1969	Gibson Cemetery	Ft. Hall Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 2 1969	Dorothy J. Jensen	C. Leland Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3598
Local Reg. No. 113
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 007 SEP 9 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 007
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 1490 Lemon St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Zoe		Ostberg	August 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Jan. 26, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Paradise Valley, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert K. McMurdie	Utah	Margaret Ann Mills	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Mrs Lorenzo Ostberg C.M.	Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1830

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer ovaries — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept, 1968, to August 22, 1969, that I last saw the deceased alive on August 22, 1969, and that death occurred at 9:00p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean Tacker 403 M.D.	Blackfoot, Idaho	Aug. 25, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 26, 1969	Riverside-Thomas Cemetery	Bingham County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 2 1969	Dorothy J. Jones	C. Dean Hill	E-466

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3599
Local Reg. No. 114
Reg. Dist. No. 600

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — SEP 9 1969
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot --RURAL
d. STREET ADDRESS (If rural, give location): Rte. 4--Box 15

3. NAME OF DECEASED (Type or Print): a. (First) EMMA; b. (Middle) J; c. (Last) PARA

4. DATE OF DEATH: (Month) Aug. (Day) 22 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 27, 1887

9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Gap, France

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Baptiste Jouve
BIRTHPLACE: France

14. MOTHER'S MAIDEN NAME: Justine Tabouret
BIRTHPLACE: France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519-42-8493B

17. INFORMANT'S OWN SIGNATURE: Morris Para
ADDRESS: Blackfoot

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: uremia, pulmonary edema

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 Mar, 1969, *to* 22 Aug, 1969, *that I last saw the deceased alive on* 22 Aug, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. E. Miller M.D. (Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: Aug 22, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: SEP 2 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: George W. Knapp

LICENSE NO.: 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 8 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

P.

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3600
Local Reg. No. 115
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham SEP 9 1969
b. CITY OR TOWN: Blackfoot
c. LENGTH OF STAY (in this place): 45yrlmo
d. FULL NAME OF HOSPITAL OR INSTITUTION: State Hospital South

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln
c. CITY OR TOWN: Shoshone
d. STREET ADDRESS (If rural, give location): Unknown

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARIANO		ECHEVARRIA	August 23 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Spanish	Never Married	?-?-1895	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheep-Herder		Spain	Spain

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unknown	518 60 5165T	Mary Payne	Med. Records-State Hospital South

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 15 Aug., 1969, *to* 23 Aug., 1969, *that I last saw the deceased alive on* 23 Aug., 1969, *and that death occurred at* 12:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
574 Leon F. Marlowe M.D.	State Hospital South-Blackfoot, Idaho	25 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	26 Aug. 69	State Hospital South	Blackfoot, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 27 1969	Dorothy J. Jones	Howard Peckham	E-338

FIRM NAME: Howard Peckham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3601
Local Reg. No. 176
Reg. Dist. No. [illegible]

BIRTH NO.

1. PLACE OF DEATH — SEP 9 1969

a. COUNTY: Bingham 001

Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot

c. LENGTH OF STAY (in this place): 1 yr 6 mo

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Twin Falls 42

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

d. STREET ADDRESS (If rural, give location): 125 Bell Street

3. NAME OF DECEASED (Type or Print): a. (First) STANLEY b. (Middle) WALTER c. (Last) KIRK

4. DATE OF DEATH (Month) (Day) (Year): August 24 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: 9 March 1903

9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Kirk — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Alice Ongley — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 8

16. SOCIAL SECURITY NO.: 561 09 9488A

17. INFORMANT'S OWN SIGNATURE: Mary Byrne — ADDRESS: Med. Records-State Hospital South

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Fulminating Infection — 2 months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 4 Aug., 1969, *to* 24 Aug., 1969, *that I last saw the deceased alive on* 24 Aug., 1969, *and that death occurred at* 9:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leon P. Marlowe M.D.

23b. ADDRESS: State Hospital South-Blackfoot, Idaho

23c. DATE SIGNED: 26 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 28, 1969

24c. NAME OF CEMETERY OR CREMATORY: State Hospital

24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: SEP 2 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: C. Dean Hill

LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form UH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3602
Local Reg. No. 418
Reg. Dist. No. 26

RECEIVED AUG 18 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Bullion st. bridge above upstream 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location): P. O. Box 622

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): Sylvester
c. (Last): Tune

4. DATE OF DEATH (Month) (Day) (Year): Aug. 4, 1969

5. SEX: Male
6. COLOR OR RACE: Wht
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 31, 1897
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months 11, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 28
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Atalla Alabama
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis Sylvester Tune — BIRTHPLACE: Blount Co Alabama
14. MOTHER'S MAIDEN NAME: Emma Hutchinson — BIRTHPLACE: Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 572-20-1804
17. INFORMANT'S OWN SIGNATURE: Frank Cavanaugh — ADDRESS: 82-296 Miles ave Indio, Calif 92201

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Known coronary artery disease — Years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Wood River 18
21c. (CITY, TOWN, OR TOWNSHIP): Hailey — (COUNTY): Blaine 070 — (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 4 '69 12 M
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Apparently either coronary or fall while fishing

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: A. S. Earle MD 583 Coroner 4 (Degree or title)
23b. ADDRESS: Box 46 Sun Valley, Idaho
23c. DATE SIGNED: 8/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 11, 1969
24c. NAME OF CEMETERY: Coachella Valley
24d. LOCATION (City, town, or county) (State): Indio, Riverside Co. Calif.

DATE REC'D BY LOCAL REG.: Aug 15-69
REGISTRAR'S SIGNATURE: Robert H. Wright - Ruth Bird
25. EMBALMER: Keith Bird — LICENSE NO.: E-373
FIRM NAME: Bird Funeral Home Hailey, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021 Rev 1 B.W.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3603
Local Reg. No. 418
Reg. Dist. No. 27

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-15o Dam-West front
LENGTH OF STAY (in this place): of dam
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magid Dam- West front side

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JESSE	CARLTON	DAYLEY	Aug. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	Aug. 11, 1954	15	0	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	High School	San Diego, Calif.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clifton V. Dayley	Coldale, Alberta Canada	Mabel Alta Carlson	Vancouver, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	518-54-6244	X Mrs Clifton V Dayley	Shoshone

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Magic Dam-West side	Hailey-(Rural)	Blaine	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8-17-69 1:45p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Swimming at Magic Dam

22. *I hereby certify that I attended the deceased from* August 19 69, *to* August 19 69, *that I last saw the deceased alive on* July 29, 19 69, *and that death occurred at* 2:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Licensed Funeral Director	Box 68 Shoshone Idaho	8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-20-1969	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 23-69	Robert W. Wright	Eddie G. Leach	E-551

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev 6-BW

FIRM NAME: Bergin Funeral Chapel, Shoshone, Ida.

DUTIES:

AUG 2 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 2 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3604
Local Reg. No. 288
Reg. Dist. No. 410

RECEIVED
SEP 12 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Bellevue
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Farm Springs Landing Magic Dam 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): River View Trailer Court

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) HENRY c. (Last) WATERBURY

4. DATE OF DEATH: (Month) Aug. (Day) 27, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married	Sept. 26, 1913	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
machanic 21	heavy duty Equ.	Canby, Minn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Willis Waterbury	Minn.	Lillian Hansen	Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-12-1653	Lillian B. Waterbury	Pasco, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 38 Cal. pistol, gun shot to the right temple of head — INTERVAL BETWEEN ONSET AND DEATH: immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

955X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
2 Sucide	car. Magicdam 31	Bellevue	070 Blaine	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8-27-69 abt 7p m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	self inflicted gun shot

22. *I hereby certify that I attended the deceased from* did not see *to* alive, 19, *that I last saw the deceased alive on* , 19, *and that death occurred at* 7: P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orville E. Driffert	583 Sheriff-Acting Coroner	Hailey, Idaho	Aug. 30, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/2/69	Mt. View Cemetery	Fairfield, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 8-69	Robert H. Wright per C.B.W.	Keith Bird	C. 373

FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 05 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 20 1969 Bureau of Vital Statistics

State File No. 3605
Local Reg. No. 353
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: BOISE 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 15 MILES FROM BOISE ON HIWAY 55
c. LENGTH OF STAY (In this place):
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: AUTO ACCIDENT HIWAY 55 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1804 IDAHO ST.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RUSSELL	GEORGE	HASKIN	AUGUST 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	white	married	FEBRUARY 22, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 08	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Law Enforcement Officer	Boise City Police	VINING, KANSAS	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOHN J. HASKINS	NO. DAKOTA	ELIZABETH HAAS	VINING, KANSAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518 32 3370	Wanda J. Haskin	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 8129

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiply Internal Injuries. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	06	13080

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
8	10	69	7P m.		Auto Collision Hiway 55. His Car rolled. 030

22. *I hereby certify that I attended the deceased from* Did Not See to Alive, 19, *that I last saw the deceased alive on* and *that death occurred at* 7P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C.O. Davis 583	Coroner	3720 Meadow Drive, Boise.	8-15-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
CREMATION 2	AUGUST 13, 69	Mt. Vu. Mausoleum	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/18/69	Henrietta Penrod	Conway Grant	E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 2 0 1969

JUN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3606
Local Reg. No. 352
Reg. Dist. No.

BIRTH NO.

RECEIVED SEP 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Boise
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural---Idaho City
c. LENGTH OF STAY (In this place) hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Spring Shores

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1318 Ada St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	S.	Nelson	Aug. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 12, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Logger & Carpenter 17	Logging	St. Joe, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Cormy Samuel Nelson	Indiana	Myrtle Simmons	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
WWII Yes / WWII	519-10-6451	X Isabell H Nelson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Drowning	18	080

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Aug. 31 1969 8 p.m.		

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard H Harlow 583 Boise Co. Coroner	Star Rt. Banks, Idaho	9 10 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/4/69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/16/69	Henrietta Penrod	G. W. Waters	E-461

FIRM NAME Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Dust

SEP 23 1969
OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 17 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3607
Local Reg. No. #76
Reg. Dist. No.

RECEIVED AUG 14 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 4 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ponderay
d. STREET ADDRESS (If rural, give location): Box 127

3. NAME OF DECEASED (Type or Print): a. (First) Thomas b. (Middle) Joseph c. (Last) Temple

4. DATE OF DEATH (Month) (Day) (Year): August 4, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 25, 1900

9. AGE (In years last birthday): 69 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance - Bonner School District 82

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas C. Temple — BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Mary Ellen Kennedy — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 05 2590

17. INFORMANT'S OWN SIGNATURE: X Elsie Temple — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of Prostate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/18, 1969, *to* 8/4, 1969, *that I last saw the deceased alive on* 8/3, 1969, *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: James R. Cathcart (Degree or title) M.D.

23b. ADDRESS: 502 N. 2nd.

23c. DATE SIGNED: 8/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 7, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 8/12/69

REGISTRAR'S SIGNATURE: Dale Coffelt

25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 11 1969
Bureau of Vital Statistics

State File No. 3608
Local Reg. No. #75
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 040 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Priest River
c. LENGTH OF STAY (in this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hiway 57-Lamb Creek rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Spokane 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cheney
d. STREET ADDRESS (If rural, give location) 1401 3rd St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Scott	Robert	Bell	Aug 5 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	May 1 1962	7				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	Grade School	Indiana	Usa

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David S. Bell	Illinois	Barbara Rapley	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	Barbara K. Bell	1401 3rd Cheney, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive accidental trauma — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple lacerations and hemorrhage
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Hwy 57 at Lamb Ck rd	Lamb Creek Bonner 040 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8/5/69 9:50 A.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Car - truck accident

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Danny D. Nelson 583 + Coroner	Sandpoint, Idaho 83864	8/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8/5/69	Sherman Funeral Home	Newport, Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/8/69	Wale Anderson	R. D. Sherman	QL749

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Sherman Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Certificate of Death

State File No. 3609
Local Reg. No. #71
Reg. Dist. No.

STATE OF IDAHO

BIRTH NO. AUG 14 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 041 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
c. LENGTH OF STAY (in this place) two years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
d. STREET ADDRESS (If rural, give location) Route 1, Box 190

3. NAME OF DECEASED (Type or Print)
a. (First) Emma
b. (Middle) Rozella
c. (Last) Hulett

4. DATE OF DEATH (Month) (Day) (Year) August 5, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Sept. 28, 1884
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin Thompson — BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Wealthy McKinley — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ----------
16. SOCIAL SECURITY NO. 485 05 2548D
17. INFORMANT'S OWN SIGNATURE Mrs M. D. Jackson — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure & depression — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral vascular accident — 8-10 Hours
DUE TO (c) Probable Hemorrhage

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 18, 1964, *to* August 5, 1969, *that I last saw the deceased alive on* August 4, 1969, *and that death occurred at* 7:30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 471 (Degree or title)
23b. ADDRESS [signature] 2 dbs
23c. DATE SIGNED 8/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 8, 1969
24c. NAME OF CEMETERY OR CREMATORY Pinecrest Cemetery
24d. LOCATION (City, town, or county) Sandpoint (State) Idaho

DATE REC'D BY LOCAL REG. 8/13/69
REGISTRAR'S SIGNATURE Dale Pederson
25. EMBALMER Dale G. Coffelt — LICENSE NO. E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3610
Local Reg. No. #80
Reg. Dist. No.

BIRTH NO.

AUG 22 1969

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Bonner

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint

c. LENGTH OF STAY (in this place): 4 months

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Montana

b. COUNTY: Lincoln

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eureka

d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): a. (First) Peter b. (Middle) V. c. (Last) KLINKE

4. DATE OF DEATH: (Month) Aug (Day) 8, (Year) 69

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: Oct 20, 77

9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Co. Commissioner

10b. KIND OF BUSINESS OR INDUSTRY: County

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lars Klinke — BIRTHPLACE: Unk

14. MOTHER'S MAIDEN NAME: Eliana Peterson — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 516-38-938A

17. INFORMANT'S OWN SIGNATURE: Peter V. Klinke Jr. — ADDRESS: Eureka, Mont.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of prostate — 5 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1968, *to* 8-8, 1969, *that I last saw the deceased alive on* 8-7, 1969, *and that death occurred at* 7:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Box 835, Sandpoint, Id 83864

23c. DATE SIGNED: 8/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 13, 69

24c. NAME OF CEMETERY OR CREMATORY: Tobacco Valley Cem.

24d. LOCATION (City, town, or county) (State): Eureka, Montana

DATE REC'D BY LOCAL REG.: 8/21/69

REGISTRAR'S SIGNATURE: Hale Alderson

25. EMBALMER: L. G. Moon, Jr. — LICENSE NO.: E-405

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 2 8 1969

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3611
Local Reg. No. #79
Reg. Dist. No.

RECEIVED AUG 22 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 041
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 1 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bonner 041
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 105 S. 1st Ave. - Shrakes Apts.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Raymond	Robert	Hunter	August 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Feb. 9, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
First Sergeant E5	U.S. Army	North Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
No record	no record	No record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	1925 - 1946	517 32 6720	Richard L. Hunt	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Alcoholism

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Months / years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Barry D. Nelson MD (Coroner)	Sandpoint Idaho	8/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 16, 1969	Lakeview Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/20/69	Dale Anderson	L. G. Moon, Jr.	E-405

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 17 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3612
Local Reg. No. #78
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner — AUG 22 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Priest Lake
c. LENGTH OF STAY in this place: 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Indian Creek

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington
b. COUNTY: Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): W. 2928 Dean

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Maurice	E.	Swank	8	9	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	5/10/16	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Civil Engineer	Spokane School Dist. 81	Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Michael Elgar Swank	Missouri	Lena Maude Peebles	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	534-18-8312	Mrs Maurice E Swank	W. 2928 Dean

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____ *and that death occurred at* 11:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Barry D Nelson M.D. Coroner	Box 475, Sandpoint, Idaho 83864	8/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-13-69	Greenwood Memorial Terrace	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/20/69	Hale Anderson	Raymond Taylor	Q1 468

FIRM NAME: Hazen & Jaeger Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 9 1969

JUN 14 1982

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUN 25 1993

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Dr. Weiland, Spokane, Wn., stated that Mr. Swank had a severe coronary heart attack three months prior to death.

Certificate of Death

STATE OF IDAHO

State File No. 3613
Local Reg. No. #52
Reg. Dist. No.

RECEIVED SEP 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 041
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bonner 041
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 521 Alder

3. NAME OF DECEASED (Type or Print)
a. (First): Nadine
b. (Middle): Louisa
c. (Last): Funkhouser

4. DATE OF DEATH: (Month) (Day) (Year): August 10, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 18, 1888

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Willard French
BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Matilda Bell
BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 533 16 4376 D

17. INFORMANT'S OWN SIGNATURE: X C. G. Funkhouser
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 4319 Cerebral Vascular — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hemonhagel — 1 mo
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Cardiac failure Chronic

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June, 1958, *to* Aug, 1969, *that I last saw the deceased alive on* Aug 8, 1969, *and that death occurred at* 4:30 P.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Munson 352 M.D.
23b. ADDRESS: Sandpoint Ida
23c. DATE SIGNED: 9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-burial
24b. DATE: Aug. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Community Cemetery
24d. LOCATION (City, town, or county) (State): Creston Washington

DATE REC'D BY LOCAL REG.: 9/9/69
REGISTRAR'S SIGNATURE: Viola Andrews

25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 3 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3614
Local Reg. No. #87
Reg. Dist. No.

RECEIVED
Bureau of Vital Statistics
AUG 26 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 041
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 041
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 920 Forest Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Forrest b. (Middle) D. c. (Last) Danielson

4. DATE OF DEATH: (Month) (Day) (Year) August 16, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: October 10, 1914

9. AGE (In years last birthday): 54 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Transport

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles G. Danielson
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Bertha Swigart
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W W II 4

16. SOCIAL SECURITY NO.: 506 10 0388

17. INFORMANT'S OWN SIGNATURE: Mrs Ruth M. Danielson ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adeno Carcinoma Prostate with metastases

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 29, 19 69, *to* Aug 16, 19 69, *that I last saw the deceased alive on* Aug 15, 19 69, *and that death occurred at* 4:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Johnson Smith MD (Degree or title) 480
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: Aug 21 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 8/25/69
REGISTRAR'S SIGNATURE: Hale Anderson

25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 0 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3615
Local Reg. No. 272
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY BONNEVILLE — AUG 2 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS — c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 350 E St. Apt.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO — b. COUNTY BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
d. STREET ADDRESS (If rural, give location) 350 E Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	THOMAS	LEMLEY	July 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	29 Sept. 1946	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
navyman		New Haven, Conn.	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lester Lemley	Guilford, Conn.	Marion Roper	West Haven, Conn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	042 38 7153	Doris M. Lemley	87 Edgar Street, East Haven, Conn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

958X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Suicide

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Suicide

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN OR TOWNSHIP) Idaho Falls (COUNTY) Bonneville (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Verna C. Bydalek Coroner	3824 E. 17th Street	8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	17 July 1969	East Lawn Cemetery	East Haven, Conn.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 19-69	Emma Bridges	Geo. A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

Barney

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 28 1969 Bureau of Vital Statistics

State File No. 3616
Local Reg. No. 273
Reg. Dist. No. 611

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 2 miles N. of Idaho Falls

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
d. STREET ADDRESS (If rural, give location) 681 Terrace Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RAYMOND	STEVEN	BARNEY	July 20 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	single	FEB. 14, 1949	20	5 / 6	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student		Wallace, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Steven Barney	Lewisville, Idaho	Mavis Culver	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Mavis Woodruff	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 8199 Multiple Trauma

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Car accident	Interstate 15	Idaho Falls / Bonneville / Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vernal Reydaleth DDS + Coroner	3824 E. 17th Idaho Falls	8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 23, 1969	Lewisville Cemetery	Lewisville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 19-69	Irma Budger	Leo A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 3617
Local Reg. No. 274
Reg. Dist. No. 610

BIRTH NO.

RECEIVED STATE OF IDAHO

AUG 28 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bonneville (07)

b. CITY OR TOWN: Idaho Falls

c. LENGTH OF STAY (If outside this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 751 Contor Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Twin Falls (42)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	MAURICE	CHARLES	YEARSLEY	July	24	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec 24, 1912	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
District Manager (56)	Boise Cascade Co.	Mennan, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Heber Yearsley	Unk.	Juli Brown,	Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II	518 18 7021	Mrs. Maurice Yearsley	IF, I

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Suicide (Gunshot) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
2 Suicide	Home 31	Idaho Falls (01) Bonneville Idaho	m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Verna Bydalek (583) + Coroner	3824 E. 17th Idaho Falls	8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	July 28-69	Cedar Butte Cemetery	Annis, Idaho, Jefferson, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 19-69	Irma Bridges	Ben Sullivan	E387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

AUG 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 16 1969
FEB 27 1970
APR 2 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3618
Local Reg. No. 293
Reg. Dist. No. 610

RECEIVED SEP 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN: Idaho Falls
LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital nursing home 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Island Park (Henry's Lake)
d. STREET ADDRESS (If rural, give location): none

3. NAME OF DECEASED (Type or Print): a. (First) ALBERTINA b. (Middle) E. c. (Last) RAHN

4. DATE OF DEATH: (Month) (Day) (Year) July 26, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept 22, 1879
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife/teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Monee, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Helmann — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Caroline Fatler — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-22-3338D
17. INFORMANT'S OWN SIGNATURE: Albert T. Fraser — ADDRESS: Idaho Henry's Lake

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Chronic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease Chronic

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/16, 1968, *to* 7/26, 1969, *that I last saw the deceased alive on* 7/26, 1969 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 54A
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 8/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Targhee Cemetery
24d. LOCATION (City, town, or county) (State): Henry's Lake, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: Sept 17, '69
REGISTRAR'S SIGNATURE: Irma Rudger
25. EMBALMER: Robert Bean
LICENSE NO.: E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-6021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 4 1969 Bureau of Vital Statistics

State File No. 3619
Local Reg. No. 282
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bonneville	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls; c. LENGTH OF STAY (In this place): 22 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042	d. STREET ADDRESS (If rural, give location): 1495 Willow Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Martha	L.	Lingren	July	30	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	November 19, 1903	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Iona, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Francis DeLaHaye Horman	England	Thecla Lingholm	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518 10 8008B	LaVerne M. Clark	Anoka, Minn

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4274

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral embolism	Instant
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Auricular fibrillation	3 weeks
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerebral Vascular Accident	4 weeks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* July 30, 1969, *that I last saw the deceased alive on* July 30, 1969, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David H. Smith 479	M.D.	Idaho Falls, Idaho	8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/2/69	Iona Cemetery	Iona Bonneville Co. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 29-69	Anna Bredger	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 3 0 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3620
Local Reg. No. 263
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 13 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dubois
d. STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
REYNOLD	STANLEY	WILLES	August 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 26, 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Garage Owner	Automobile	Lehi, Utah.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lyman Benjamin Willes	Utah	Sarah Ann Munns	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.I	519-03-5468	Nevada Willes	Dubois, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardiac Decompensation	3 mo.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	Yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Emphysema.	Yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1 Aug, 1969, *to* 3 Aug, 1969, *that I last saw the deceased alive on* 3 Aug, 19 69 *and that death occurred at* 8:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Joseph M Hatch M.D.	M.D.	Idaho Falls, Idaho.	Aug 4, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 6, 1969	Dubois	Dubois, Clark, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 7-1969	Lena Burgess	Bruce A. Eckersell Bruce A. Eckersell	E-404

Federal Security Agency
United States Public Health Service

Form DH-60021

FIRM NAME: Eckersell Memorial Chapel

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 1 7 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3621
Local Reg. No. 267
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 19 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls Bureau of Vital Statistics
c. LENGTH OF STAY (In this place): 32 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LDS Extended care Unit 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 2121 Santaleno Drive

3. NAME OF DECEASED (Type or Print): a. (First) Winifred; b. (Middle); c. (Last) Hickman

4. DATE OF DEATH: (Month) August (Day) 4 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 21, 1892

9. AGE (In years last birthday): 77
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): St. George, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Adolphus Rennie Whitehead
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mary Esther Wells
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 528 26 6521

17. INFORMANT'S OWN SIGNATURE: Winston N. Hickman
ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

794X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Causes incident to old age — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1969 *to* August, 19 69, *that I last saw the deceased alive on* Aug. 4, 19 69, *and that death occurred at* 6 — 12 m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. J. Bingham (Degree or title) MD

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: Aug. 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 8/7/69

24c. NAME OF CEMETERY OR CREMATORY: Ogden City Cemetery

24d. LOCATION (City, town, or county) (State): Ogden, Utah

DATE REC'D BY LOCAL REG.: Aug. 14-'69

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED AUG 13 1969 Bureau of Vital Statistics

State File No. 3622
Local Reg. No. 264
Reg. Dist. No. 611

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (ID)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Irwin
c. LENGTH OF STAY (In this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway # 26 (ID2)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (565)
a. STATE: California (05)
b. COUNTY: Sacramento
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sacramento
d. STREET ADDRESS (If rural, give location): 2667 11th Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Janice; b. (Middle); c. (Last) Lake
4. DATE OF DEATH: (Month) August (Day) 4 (Year) 1969
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: August 9, 1957
9. AGE (In years last birthday): 11
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (03)
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Richard A. Lake
BIRTHPLACE: California
14. MOTHER'S MAIDEN NAME: Marie Raymond
BIRTHPLACE: California
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: T. Douglas Kinney
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

8/19/69

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiple trauma (Car accident)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Car accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Highway 26 (16)
21c. (CITY, TOWN, OR TOWNSHIP) Palisade (Irwin) (COUNTY) Bonneville (STATE) Idaho

21d. TIME OF INJURY: (Month) 8 (Day) 4 (Year) 69 (Hour) 1:00 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE: Vernal C. Rydalch (553) (Degree or title) Coroner
23b. ADDRESS: 3824 E. 17th Idaho Falls Idaho
23c. DATE SIGNED: 8-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal (3)
24b. DATE: 8/7/69
24c. NAME OF CEMETERY OR CREMATORY: Woodland Cemetery
24d. LOCATION (City, town, or county) Woodland (State) California

DATE REC'D BY LOCAL REG.: Aug. 9-1969
REGISTRAR'S SIGNATURE: Emma Rudges
25. EMBALMER: Ralph M. Wood Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3623
Local Reg. No. 275
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville AUG 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY IN THIS PLACE one day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho Falls L.D.S 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Bingham 005
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley
d. STREET ADDRESS (If rural, give location) 131 So. Holmes

3. NAME OF DECEASED (Type or Print) a. (First) Jack b. (Middle) Richard c. (Last) Priest

4. DATE OF DEATH (Month) Aug (Day) 5 (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Aug 21, 1891

9. AGE (In years last birthday) 77

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farmer

11. BIRTHPLACE (State or foreign country) Taylor Idaho

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME William E. Priest BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Joan Simpson BIRTHPLACE Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Vernon Priest ADDRESS

8161

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) SHOCK FROM MULTIPLE INJURIES — INTERVAL BETWEEN ONSET AND DEATH 30 HRS

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CRUSHED LARYNX, EXTENSIVE LACERATIONS DISLOCATED RT HIP,
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. LIVER DISEASE (POOR CLOTTING) EMPHYSEMA, DIABETES, ASHD

19a. DATE OF OPERATION AUG 4

19b. MAJOR FINDINGS OF OPERATION CRUSHED LARYNX, MULTIPLE FACIAL LAC. DISLOC HIP

20. AUTOPSY? Yes ☐ No ☒ RE

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) ACCIDENT

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) HIWAY NEAR SHELLEY

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) AUG (Day) 4 (Year) 1969 (Hour) 7:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? WIFE DRIVING — STRUCK ABUTMENT

22. I hereby certify that I attended the deceased from Aug 4, 1969, to Aug 5, 1969, that I last saw the deceased alive on Aug 5, 1969, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS 756 Orchard, Idaho Falls

23c. DATE SIGNED 8-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-9-69

24c. NAME OF CEMETERY OR CREMATORY Hillcrest

24d. LOCATION (City, town, or county) Shelley (State) Idaho

DATE REC'D BY LOCAL REG. Aug 15 69

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER

LICENSE NO. E-444

FIRM NAME: Nalder Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3624
Local Reg. No. 268
Reg. Dist. No. 6/6

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville (01) AUG 19 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 1 year

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (01)
a. STATE Idaho b. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls

d. FULL NAME OF HOSPITAL OR INSTITUTION 1090 North Boulevard
d. STREET ADDRESS (If rural, give location) 1090 North Boulevard

3. NAME OF DECEASED (Type or Print) a. (First) Karon b. (Middle) Raye c. (Last) Whitehead

4. DATE OF DEATH (Month) (Day) (Year) August 6 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH April 23, 1947

9. AGE (In years last birthday) 22
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (01)

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Rigby, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Don B. Morgan
BIRTHPLACE Idaho

14. MOTHER'S MAIDEN NAME Ella Lindsay
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 54 3449E

17. INFORMANT'S OWN SIGNATURE Don B. Morgan ADDRESS Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ofer dose of Barbiturates

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) 2 Suicide

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Home (01)

21c. (CITY, TOWN OR TOWNSHIP) Idaho Falls (01) (COUNTY) Bonne. (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-5-69 9 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Vernal Rydalch (Degree or title) Coroner

23b. ADDRESS 3824 E. 17th

23c. DATE SIGNED 8-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/11/69

24c. NAME OF CEMETERY OR CREMATORY Iona Cemetery

24d. LOCATION (City, town, or county) (State) Iona Bonneville Co. Idaho

DATE REC'D BY LOCAL REG. Aug. 14-1969

REGISTRAR'S SIGNATURE Emma Rudges

25. EMBALMER Ralph M. Wood Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3625
Local Reg. No. 269
Reg. Dist. No. 610

BIRTH NO.

AUG 19 1969

1. PLACE OF DEATH a. COUNTY: Bonneville	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls Bureau	c. LENGTH OF STAY (In this place): 1 day
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042	d. STREET ADDRESS (If rural, give location): 138 11th Street

3. NAME OF DECEASED (Type or Print)	a. (First): Eldredge (Roy)	b. (Middle): LeRoy	c. (Last): Howes	4. DATE OF DEATH (Month) (Day) (Year): August 7 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: December 10,1908	9. AGE (In years last birthday): 60 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator 26	10b. KIND OF BUSINESS OR INDUSTRY: Apartment Houses	11. BIRTHPLACE (State or foreign country): Magrath, Alberta, Canada	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Culbert Roy Howes	BIRTHPLACE: Utah	14. MOTHER'S MAIDEN NAME: Leah Leorene Hoggard	BIRTHPLACE: Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: Not Available	17. INFORMANT'S OWN SIGNATURE: Ruth L. Howes	ADDRESS: Idaho Falls, Idaho	

MEDICAL CERTIFICATION

185X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma of the prostate with metastasis to the bone

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Bonneville, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-19, 1969, *to* 8-7, 1969, *that I last saw the deceased alive on* 8-7, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: S. B. Davis Shaworth LC 156 (Degree or title)	23b. ADDRESS: Idaho Falls, Idaho	23c. DATE SIGNED: 8-12-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8/9/69	24c. NAME OF CEMETERY OR CREMATORY: Teton Cemetery
24d. LOCATION (City, town, or county): Teton	(State): Idaho	
DATE REC'D BY LOCAL REG.: Aug 14-1969	REGISTRAR'S SIGNATURE: Anna Bridger	25. EMBALMER: Ralph M. Wood Ralph M. Wood
LICENSE NO.: 413		

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 5 1969
NOV 1 8 1969
JUN 9 1971
JUN 1 8 1971
NOV 8 1974
OCT 26 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3626
Local Reg. No. 270
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 19 1969

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1644 Brentwood

3. NAME OF DECEASED (Type or Print) a. (First) Curtis b. (Middle) Lee c. (Last) Collins
4. DATE OF DEATH (Month) August (Day) 9 (Year) 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 26, 1928
9. AGE (In years last birthday) 40 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician 08
10b. KIND OF BUSINESS OR INDUSTRY Idaho Nuclear Co.
11. BIRTHPLACE (State or foreign country) Odell, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Elmer Collins BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Edna Griffen BIRTHPLACE Arkansas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1947 - 1951
16. SOCIAL SECURITY NO. 432 40 8818
17. INFORMANT'S OWN SIGNATURE x Mrs. Curtis Collins ADDRESS Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4119

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) STENOSIS, SEVERE WITH INSUFFICIENCY CORONARY ARTERIES

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ARTERIOSCLEROSIS, AND ATHEROMATOUS PLAQUES, CORONARY ARTERIES

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) IDAHO FALLS (COUNTY) BONNEVILLE (STATE) IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Hazel D. McGaffey (Degree or title) HAZEL D. MC GAFFEY, M.D.
23b. ADDRESS 2525 SOUTH BOULEVARD, IDAHO FALLS
23c. DATE SIGNED 8-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 8/13/69
24c. NAME OF CEMETERY OR CREMATORY Terrace Heights Memorial
24d. LOCATION (City, town, or county) Yakima (State) Washington

DATE REC'D BY LOCAL REG. Aug 15-1969
REGISTRAR'S SIGNATURE Lenore Ridgley
25. EMBALMER Ralph M. Wood Ralph M. Wood
LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 6 1969

MAR 1 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3627
Local Reg. No. 276
Reg. Dist. No. 610

BIRTH NO.

AUG 2 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 54 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Iona
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter day Saints Hospital 042	d. STREET ADDRESS (If rural, give location): Box 24

3. NAME OF DECEASED (Type or Print) a. (First): Annabell	b. (Middle):	c. (Last): Wilson	4. DATE OF DEATH (Month) (Day) (Year): August 9 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Sept. 1, 1882	9. AGE (In years last birthday): 86 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Ogden, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Austin C. Brown	BIRTHPLACE: Iowa	14. MOTHER'S MAIDEN NAME: Meriah Ballantyne	BIRTHPLACE: Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 529 72 9205 T	17. INFORMANT'S OWN SIGNATURE: Alvin Scoresby	ADDRESS: Iona, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Hemorrhage	4 weeks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 6.19.69	19b. MAJOR FINDINGS OF OPERATION: Small Bowel obstruction	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Jim S Hatch 210	(Degree or title): MD	23b. ADDRESS: Idaho Falls	23c. DATE SIGNED: 8-14-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 8/12/69	24c. NAME OF CEMETERY OR CREMATORY: Ogden City Cemetery	24d. LOCATION (City, town, or county) (State): Ogden Utah
DATE REC'D BY LOCAL REG.: Aug. 18-'69	REGISTRAR'S SIGNATURE: Emma Bridges	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3628
Local Reg. No. 171
Reg. Dist. No. 610

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 AUG 19 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho
c. LENGTH OF STAY (in this place) 8yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2175 Valley Dr. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
d. STREET ADDRESS (If rural, give location) 2175 Valley Dr.

3. NAME OF DECEASED (Type or Print)
a. (First) LLOYD
b. (Middle) CARR
c. (Last) YOUNG

4. DATE OF DEATH (Month) (Day) (Year) Aug. 11, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan 17, 1913
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Rep. 08
10b. KIND OF BUSINESS OR INDUSTRY Soc. Sec. Adm.
11. BIRTHPLACE (State or foreign country) Fairmont, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Carroll Young — BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Stella Morris — BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 519 24 2915
17. INFORMANT'S OWN SIGNATURE Mary Jo Young — ADDRESS Ida. Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 5-10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) None known
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None known

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

Pt. hasn't been seen for at least 1 or 2 yrs by a physician.

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:40a *m., from the causes and on the date stated above.*

23a. SIGNATURE Carlon A. Simmons, M.D. 928 (Degree or title)
23b. ADDRESS 195 College, Idaho Falls, Idaho
23c. DATE SIGNED 8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Aug. 14, 69
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Aug. 14-69
REGISTRAR'S SIGNATURE Anna Bridger
25. EMBALMER Bill Sullivan
LICENSE NO. E 387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 4 1987

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 2 8 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3629
Local Reg. No. 277
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (07)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville (07)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 305 6th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John (Jack)	Walter	Malloy	August	14	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	May 2, 1899	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heating & Maintenance Man
10b. KIND OF BUSINESS OR INDUSTRY: Theater
11. BIRTHPLACE (State or foreign country): Murray, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter C. Malloy — BIRTHPLACE: Ia.
14. MOTHER'S MAIDEN NAME: Charlotte Birch — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 09 1813A
17. INFORMANT'S OWN SIGNATURE: James E. Malloy — ADDRESS: Ucon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

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MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMATOSIS, LIVER, WITH METASTATIC CARCINOMA TO ADRENALS, BILATERAL

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death ARTERIOSCLEROSIS, MODERATELY SEVERE, CORONARY ARTERIES AND AORTA

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NONE
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) IDAHO FALLS (COUNTY) BONNEVILLE (STATE) IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L. McGaffey, M.D. 342
23b. ADDRESS: 2525 South Boulevard, Idaho Falls
23c. DATE SIGNED: 8-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 8/16/69
24c. NAME OF CEMETERY OR CREMATORY: Murray Cemetery
24d. LOCATION (City, town, or county) (State): Murray, Utah

DATE REC'D BY LOCAL REG.: Aug 19-69
REGISTRAR'S SIGNATURE: Duncan Bridges
25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3630
Local Reg. No. 278
Reg. Dist. No. 610

BIRTH NO.

RECEIVED SEP 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, R#3
c. LENGTH OF STAY (In this place): 3½ Mo.,
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Basalt,
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Ruby Mary b. (Middle) c. (Last) Nelson

4. DATE OF DEATH: (Month) Aug (Day) 16 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nove 27 1893
9. AGE (In years last birthday): 75 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mt. Pleasent, Utah
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Joseph Johnson — BIRTHPLACE: Mt. Pleasent
14. MOTHER'S MAIDEN NAME: Cecilia Marie Hendricksen, — BIRTHPLACE: Mt Pleasent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Nettie Meham — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial infarct c̄ decompensation	several days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic cardiovascular disease	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus	10 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 22 March, 1951, *to* 15 July, 1969, *that I last saw the deceased alive on* 15 July, 1969, *and that death occurred at* 4:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Walter G Hoge 237 (Degree or title) MD
23b. ADDRESS:
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 20 '69
24c. NAME OF CEMETERY OR CREMATORY: Basalt
24d. LOCATION (City, town, or county): R# 1 Shelley, (State) Idaho

DATE REC'D BY LOCAL REG.: Aug. 22, '69
REGISTRAR'S SIGNATURE: Anna Bredger
25. EMBALMER: Lloyd M Nalder
LICENSE NO.: E 275

FIRM NAME: Nalder's Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3631
Local Reg. No. 283
Reg. Dist. No. 6/0

RECEIVED SEP 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 836 Whittier

3. NAME OF DECEASED (Type or Print): a. (First) Viola b. (Middle) Josephine c. (Last) Conan

4. DATE OF DEATH: (Month) August (Day) 17 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 28, 1895
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hooper, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Wadsworth — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Henrietta McCloy — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 12 7845
17. INFORMANT'S OWN SIGNATURE: Norma B Conan — ADDRESS: Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10 1967, to Aug 17, 1969, that I last saw the deceased alive on Aug 17, 1969, and that death occurred at 7:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE: Bryant Weeks M D (Degree or title)
23b. ADDRESS: 1585 So. Boulevard, Idaho Falls
23c. DATE SIGNED: 8/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/20/69
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Aug 29-69
REGISTRAR'S SIGNATURE: Emma Burgess
25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3632
Local Reg. No. 293
Reg. Dist. No. 6/0

RECEIVED
SEP 16 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Idaho Falls Rest Home 361

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 232
a. STATE Idaho
b. COUNTY Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) Alvira c. (Last) Clifford Livermore
4. DATE OF DEATH (Month) August (Day) 19 (Year) 1969
5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH March 21, 1885
9. AGE (In years last birthday) 85
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Ogden, Utah
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Franklin G. Clifford
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Leora Talmage
BIRTHPLACE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Cleo Barnes
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Q.S. 14-0.
INTERVAL BETWEEN ONSET AND DEATH Several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) IDAHO FALLS, BONNEVILLE, IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-15- 1967, to 8-19 1969, that I last saw the deceased alive on 8-14, 1969, and that death occurred at 8:50 P m., from the causes and on the date stated above.

23a. SIGNATURE C. T. Barnes (Degree or title) 294
23b. ADDRESS 798 S. Blvd., Idaho Falls, Id.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY Cedar Butte Cemetery
24d. LOCATION (City, town, or county) (State) Menan, Idaho

DATE REC'D BY LOCAL REG. Sept. 14-'69
REGISTRAR'S SIGNATURE Anna Rudges
25. EMBALMER Theo Spillers
LICENSE NO. E-532
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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Certificate of Death

STATE OF IDAHO

State File No. 3633
Local Reg. No. 279
Reg. Dist. No. 610

RECEIVED SEP 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville (01)
b. CITY OR TOWN Rural, Ida. Falls
c. LENGTH OF STAY (If outside corporate limits)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville (01)
c. CITY OR TOWN Idaho Falls
d. STREET ADDRESS (If rural, give location) 900 Ordin, Dr.

3. NAME OF DECEASED (Type or Print)
a. (First) DENNIS
b. (Middle) DEAN
c. (Last) GRAY

4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 69

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH April 13, 1949
9. AGE (In years last birthday) 20
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY University
11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Gray
BIRTHPLACE Idaho Falls, Ida.
14. MOTHER'S MAIDEN NAME Alberta Mawson
BIRTHPLACE Ida. Falls, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 58 1109
17. INFORMANT'S OWN SIGNATURE William P Gray
ADDRESS Ida. Falls, I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sub dural hematoma (brain)
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) auto vs train accident
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH
(a) ~ two hours
(b) ~ two hours

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. patient had a cardiac arrest during surgery and died

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION subdural hematoma right temporal area
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ✓ SUICIDE HOMICIDE (Specify) I
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 13600 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 - 20 - 69 ~3PM m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? truck vs train accident

22. I hereby certify that I attended the deceased from 8-20, 19 69, to 8-20, 19 69, that I last saw the deceased alive on 5:10 PM, 19 8-20-69, and that death occurred at 5:10 P m., from the causes and on the date stated above.

23a. SIGNATURE George Barnard M.D. (Degree or title)
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 8-20-69.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 25, 69
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Sept 9-69
REGISTRAR'S SIGNATURE Rena Rudger
25. EMBALMER Buck Sullivan
LICENSE NO. E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-630-2

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 10 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Jan 14, 1971

Certificate of Death

STATE OF IDAHO

State File No. 3634
Local Reg. No. 210
Reg. Dist. No. 610

BIRTH NO. 69-7970

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101 SEP 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First) Camille b. (Middle) Maria c. (Last) High

4. DATE OF DEATH (Month) (Day) (Year) August 20, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH August 20, 1969

9. AGE (In years last birthday) IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 02

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gregory High BIRTHPLACE Idaho Falls, Idaho

14. MOTHER'S MAIDEN NAME Candus Merrell BIRTHPLACE Blackfoot, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Gregory High ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 7691 Preventable infant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature labor
DUE TO (c) Premature Rupture of membranes

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 20, 19 69, *to* August 20, 19 69, *that I last saw the deceased alive on* August 20, 19 69, *and that death occurred at* 12:20a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Kulon D Robertson 612 (Degree or title) M.D.

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED August 22, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE August 22, 1969

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) Blackfoot (State) Idaho

DATE REC'D BY LOCAL REG. Aug 26-'69

REGISTRAR'S SIGNATURE Emma Bridges

25. EMBALMER

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss. JAN 4 - 1971

County of ..... }

Certificate No. 69-3634

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for Baby Girl High (Name on Original Certificate) who died (Was Born or Died) on August 20, 1969 (Date of Event)

in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date) are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#3 Name of child	Baby Girl High	Camille Maria High

Subscribed and sworn to before me this 28th day of December, 1970

Arch E. Hess

Notary Public, residing at Shelley Idaho

My commission expires 3-1-74

(Seal)

Signed Gregory L High

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho }

County of Bingham } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 28 day of December, 1970

Arch E. Hess

Notary Public, residing at Shelley

My commission expires 3-1-74

(Seal)

Signed Fred K Merrell

(Signature of Any Credible Person)

Route 1 Box 179 Blackfoot Idaho

(Street Address, City, State)

FORM DH 60-155

Affidavit [illegible] Original Certificate of Birth or Death

State of [illegible] 9-3634

County of [illegible] State of [illegible]

The undersigned does [illegible]

for [illegible] 1969

(Date of Event)

[illegible] of his knowledge, the

[illegible] are:

MAIL TO [illegible]

Subscribed and [illegible]

[illegible] that they

are [illegible]

Subscribed and [illegible]

Signature

[illegible]

Notary Public, residing at

My commission expires

(Seal)

Form No. [illegible]

Certificate of Death

STATE OF IDAHO

State File No. 3635
Local Reg. No. 279
Reg. Dist. No. 6/D

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ucon
d. STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	KEITH	HUGHES	August 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Feb. 7, 1927	42				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Livestock specialist	Sugar	Mendon, Utah.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Owen Hughes	Mendon, Ut.	Pearl Allen	Hyrum, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.II	528-40-8755	Joan C. Hughes	Ucon, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myeloblastic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 19, 1969, *to* Aug 20, 1969, *that I last saw the deceased alive on* Aug 20, 1969, *and that death occurred at* 6:50P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harvey A. Hatch 205	M.D.	Idaho Falls, Idaho.	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 23, 1969	Mendon, Utah.	Mendon, Cache Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 21-69	Emma Bridges	Bruce A. Eckersell Bruce A. Eckersell	E-404

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 11 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3636
Local Reg. No. 281
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 643

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ISABELLA
b. (Middle): O'HALLORAN
c. (Last): HAMMOND

4. DATE OF DEATH (Month) (Day) (Year): August 21, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3-28-1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Challis, Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Robert Curry Beardsley — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Eleanor Francis O'Halloran — BIRTHPLACE: Louisiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-44-2594
17. INFORMANT'S OWN SIGNATURE: Mildred Kimpton — ADDRESS: Challis, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4339 Cerebral Arteriosclerosis and Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-3, 1969, *to* 8/21, 1969, *that I last saw the deceased alive on* 8/21, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 54 (Degree or title)
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 8/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-24-69
24c. NAME OF CEMETERY OR CREMATORY: Challis
24d. LOCATION (City, town, or county) (State): Challis, Idaho

DATE REC'D BY LOCAL REG.: Aug. 28-69
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: C. W. Marvel
LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Marvel Mem. Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3637
Local Reg. No. 296
Reg. Dist. No. 611

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (160) SEP 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Near Caribou City
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 2970 East Lincoln

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Clarence	E.	Fuger	August 22 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	November 3, 1922	46				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipefitter	Industrial Contr.	Driggs, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clarence E. Fuger	Illinois	Violet M. McElroy	Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II	518 20 3358	Dorothy M. Fuger	Idaho Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) EDEMA & CONGESTION, LUNGS, ACUTE — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) PROBABLE CARDIAC ARRYTHMIA AND ARREST (ETIOLOGY UNDETERMINED)
DUE TO (c) ARTERIOSCLEROSIS, MILD, CORONARY ARTERIES

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. PULMONARY EMPHYSEMA, MODERATELY SEVERE.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
NONE		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McGaffey HAZEL L. MC GAFFEY, M.D. 3420 PATHOLOGIST	2525 SOUTH BOULEVARD, IDAHO FALLS	9/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/28/69	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 15 '69	Anna Burgess	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63022

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 3 0 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 2 5 1982

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 4 1969

Bureau of Vital Statistics

State File No. 3638
Local Reg. No. 295
Reg. Dist. No. 6 / D

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 951 Bannock

3. NAME OF DECEASED (Type or Print) a. (First) JANET b. (Middle) L. c. (Last) MOFFAT THORNOCK LANDON

4. DATE OF DEATH (Month) (Day) (Year) Aug 23, 1969

5. SEX famale

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH March 20, 1894

9. AGE (In years last birthday) 75
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saleswoman 24

10b. KIND OF BUSINESS OR INDUSTRY clothing stores

11. BIRTHPLACE (State or foreign country) Laketown, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Smith Moffat BIRTHPLACE Craftshead, Scotland

14. MOTHER'S MAIDEN NAME Lois Gunn BIRTHPLACE Philadelphia, Penna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Beth Thornock Orr ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4409 Terminal Pneumonia
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis &
DUE TO (c) Causes incidental to age

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 4-5 day

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19 67, to Aug 23, 19 69, that I last saw the deceased alive on Aug 22, 19 69, and that death occurred at _____ m., from the cause and on the date stated above.

23a. SIGNATURE Harvey A. Hatch 208 (Degree or title) M.D.

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED Aug 26, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug 26, 1969

24c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery

24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Sept. 2-1969

REGISTRAR'S SIGNATURE Anna Rudges

25. EMBALMER Leo A. Williams

LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3939
Local Reg. No. 286
Reg. Dist. No. 611

RECEIVED SEP 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 24 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Ellen	Moore	August	24	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	August 17, 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Logan, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James A. Ferguson — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Mary Gneiting — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519 32 3045
17. INFORMANT'S OWN SIGNATURE: M. Louise Malloy — ADDRESS: Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-15, 1968, *to* 8/24, 1969 *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title)
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 8/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/27/69
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Ida ho

DATE REC'D BY LOCAL REG.: Sept. 2-'69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 8 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3649
Local Reg. No. 249
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville — SEP 10 1969
b. CITY OR TOWN: Idaho Falls — Bureau of Vital Statistics — LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 441 7th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lula		Moss	August	24	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	July 7, 1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Claryville, Kentucky
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Christian Kraft — BIRTHPLACE: USA
14. MOTHER'S MAIDEN NAME: Emma Uelana Brickler — BIRTHPLACE: USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 48 2878A
17. INFORMANT'S OWN SIGNATURE: Orval James Moss — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adenocarcinoma-Rt. Breast — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1967, *to* 24 August, 1969, *that I last saw the deceased alive on* 24 Aug., 1969, *and that death occurred at* 7:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orval Hall, Sr.	M.D.	Rigby, Idaho	27 Aug. 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/28/69	Ririe Shelton Cemetery	Ririe Idaho

DATE REC'D BY LOCAL REG.: Sept. 8 '69
REGISTRAR'S SIGNATURE: Emma Rudges
25. EMBALMER: Ralph M. Wood — LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 5 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 5 1981

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3641
Local Reg. No. 290
Reg. Dist. No. 610

Certificate of Death

RECEIVED
SEP 12 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 419 4th St.

3. NAME OF DECEASED (Type or Print)
a. (First): BLANCHE
b. (Middle): KERR
c. (Last): WESSEL

4. DATE OF DEATH (Month) (Day) (Year): Aug 24, 1969

5. SEX: Fem.
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 9, 1910
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Payson, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert L. Kerr — BIRTHPLACE: Payson, Utah
14. MOTHER'S MAIDEN NAME: Ethel M. Wilson — BIRTHPLACE: Aukland, New Zeland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 09 2833
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: IF, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinomatosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Carcinoma of left breast — 2 yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 1/12/68
19b. MAJOR FINDINGS OF OPERATION: Carcinoma, left breast.
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/12, 1968, *to* 8/24, 1969, *that I last saw the deceased alive on* 8/21, 1969 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: 544-4th Idaho Falls
23c. DATE SIGNED: 9/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 28, 69
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 9-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E387

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Buck- Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 24 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

JAN 15 1971

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

MAY 31 1979

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

MAR 19 1981

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3642
Local Reg. No. 271
Reg. Dist. No. 670

RECEIVED SEP 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah
b. COUNTY: Weber
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ogden
d. STREET ADDRESS (If rural, give location): 2465 Monroe Boulevard

3. NAME OF DECEASED (Type or Print): a. (First) FRANCES b. (Middle) MAY c. (Last) ANDERSON

4. DATE OF DEATH: (Month) August (Day) 26 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: December 2, 1889

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Davis, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown Burrell
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: John S Anderson
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pancreatitis
INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-21, 1969, *to* 8/26, 1969 *that I last saw the deceased alive on* 8/26, 1969, *and that death occurred at* 11:55 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) M. D.
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 9/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 10-69
REGISTRAR'S SIGNATURE: Verna Burgess
25. EMBALMER: [signature]
LICENSE NO. E-380
FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-630 (2)

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3643
Local Reg. No. 293
Reg. Dist. No. 610

BIRTH NO.

RECEIVED SEP 12 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Bonneville (C) b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): Bureau of Vital Statistics d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville (C) b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls d. STREET ADDRESS (If rural, give location): 258 Chamberlain

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Pauline	Vogel	Gray	Aug 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	Aug 25, 1894	75	0	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Butte, Montana	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
August Vogel	Iowa	Margaret Gamwells	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		August R. Gray	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute congestive failure / 10 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A S H D
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Wendell L Nielsen 390 (Degree or title) MD	Idaho Falls	9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 2, 1969	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 9-'69	Anna Rudges	Leo A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3644
Local Reg. No. 284
Reg. Dist. No. 610

BIRTH NO.

SEP 23 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bonneville 001	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (If in this place) 2 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L. D. S. Hospital 042	d. STREET ADDRESS (If rural, give location) 606 Beeson

3. NAME OF DECEASED (Type or Print)	a. (First) Blanche	b. (Middle) Stevens	c. (Last) Murphy	4. DATE OF DEATH (Month) (Day) (Year) 8-28-69
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan 13, 1892	9. AGE (In years last birthday) 77 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Huntington, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathan Henry Stevens	BIRTHPLACE Grantsville, Utah	14. MOTHER'S MAIDEN NAME Mary Chase	BIRTHPLACE Kaysville, Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-16-6024B	17. INFORMANT'S OWN SIGNATURE X [signature]	ADDRESS Pocatello, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 20, 19 69 *to* Aug 28, 19 69, *that I last saw the deceased alive on* Aug 28, 19 69, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Byron T Weeks 556 MD (Degree or title)	23b. ADDRESS 1585 So. Boulevard, Idaho Falls	23c. DATE SIGNED 9-8-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal For Burial 3	24b. DATE Sept. 2, 1969	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Sept 15, 1969	REGISTRAR'S SIGNATURE Anna Bridges	25. EMBALMER Bice Sullivan	LICENSE NO. E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (IDA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 17 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3645
Local Reg. No. 40-69
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 1 mth.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry, RR #1
d. STREET ADDRESS (If rural, give location): (Paradise Valley)

3. NAME OF DECEASED (Type or Print)
a. (First): REBECCA
b. (Middle): MAY
c. (Last): NELSON

4. DATE OF DEATH (Month) (Day) (Year): August 9, 1969

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 9-24-1890

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Grand Island, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Smyth Durnin
BIRTHPLACE: Ontario, Can.

14. MOTHER'S MAIDEN NAME: Ida May Gillett
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 520-24-9700

17. INFORMANT'S OWN SIGNATURE: Lois M Parker
ADDRESS: RR #1, Bonners Ferry

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7960

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Respiratory Failure
INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Diabetes

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19 68, *to* 8/9, 1969, *that I last saw the deceased alive on* 8/9, 1969, *and that death occurred at* 1:35 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: Bonners Ferry, Idaho
23c. DATE SIGNED: 8-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8-10-69
24c. NAME OF CEMETERY OR CREMATORY: Crown Hill Cemetery
24d. LOCATION (City, town, or county) (State): Powell Park Wyoming

DATE REC'D BY LOCAL REG.: Aug. 13, 1969
REGISTRAR'S SIGNATURE: Myrla Stone
25. EMBALMER: Emile Dion
LICENSE NO.: E 536

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3646
Local Reg. No. 41-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED AUG 21 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (In this place): 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moyie Springs
d. STREET ADDRESS (If rural, give location): P. O. Box #17

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILLIAM	THOMAS	STEPHENS	August 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 5, 1901	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sawmill Worker	Lumbering	Addie, Washington	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hiram Stephens	Missouri	Saddie Benner	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		518-01-5663	Earl T. Stephens	Moyie Springs, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: inst

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 2 Pres. Coronary occlusions

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 1969 *to* 8/15, 1969, *that I last saw the deceased alive on* 8/15, 1969, *and that death occurred at* 10 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward [illegible]	MD	Bonners Ferry Ida	8/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/18/69	Paradise Valley Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 19, 1969	Virgyla Stone	[illegible] Malone	E-453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

AUG 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3647
Local Reg. No. 42-69
Reg. Dist. No. 100

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): P. O. Box #583

3. NAME OF DECEASED (Type or Print): a. (First) BLANCHE b. (Middle) ELLEN c. (Last) CURTIS

4. DATE OF DEATH (Month) (Day) (Year): August 18, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: January 9, 1889

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Hillsboro, North Dakota

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Coughlin
BIRTHPLACE: Jefferson City, Wisconsin

14. MOTHER'S MAIDEN NAME: Molina Sannon
BIRTHPLACE: Tjronjam, Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Merriam E Curtis ADDRESS: Colville, Wn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 4419 Ruptured Aortic Aneurysm

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1968, *to* 8/18, 1969, *that I last saw the deceased alive on* 8/18, 1969, *and that death occurred at* 10 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Bonners Ferry
23c. DATE SIGNED: 8/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/21/69
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county): Bonners Ferry (State): Idaho

DATE REC'D BY LOCAL REG.: Aug. 24, 1969
REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature]
LICENSE NO.: E-453
FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: OCT 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
AUG 13 1969
Bureau of Vital Statistics

State File No. 3648
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Camas 130
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield
c. LENGTH OF STAY (In this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home at Fairfield, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Camas 130
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Leo
b. (Middle): Wayne
c. (Last): Cox

4. DATE OF DEATH: (Month) August (Day) 4, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 5, 1937

9. AGE (In years last birthday): 32

IF UNDER 1 YR. Months | Days

IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment Operator

10b. KIND OF BUSINESS OR INDUSTRY: Wendell Mill

11. BIRTHPLACE (State or foreign country): Fairfield, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wayne Woodson Cox — BIRTHPLACE: Egin, Idaho

14. MOTHER'S MAIDEN NAME: Lydia LaRae Gallup — BIRTHPLACE: Ririe, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-38-0076

17. INFORMANT'S OWN SIGNATURE: X Jaquline Marie — ADDRESS: Co[illegible]field, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): D. O A.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Occlusion (History) — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 Aug 69 *, 19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at* 8:15 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Marion J Kerns 279 (Degree or title): M.D.

23b. ADDRESS: Fairfield, Idaho

23c. DATE SIGNED: 6 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 7, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountain View

24d. LOCATION (City, town, or county) (State): Fairfield, Idaho

DATE REC'D BY LOCAL REG.: 11 Aug 1969

REGISTRAR'S SIGNATURE: Estelle Vaught

25. EMBALMER: Fred J Nelson

LICENSE NO.: E-504

FIRM NAME: Thompson Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

JUL 30 1980

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3649
Local Reg. No. 366
Reg. Dist. No. 360

RECEIVED AUG 12 1969

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital 052

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 596 Filer Ave. W.

3. NAME OF DECEASED (Type or Print)
a. (First): Elna
b. (Middle): E.
c. (Last): Jacky

4. DATE OF DEATH (Month) (Day) (Year): August 1, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: November 29, 1926
9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Otto Jacky — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Sadie E. Wilson — BIRTHPLACE: Spencer, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Wilma Keyser — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5191

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute pulmonary edema	3 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Etiology of Edema - unkown - sudden	5-6 days
DUE TO (c)	Broncho pneumonia Fluid loss 12% burn area	3 days
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Mental Retardation - unkown	15 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-17-69, 19__, *to* 8-1-69, 19__, *that I last saw the deceased alive on* 8-1-69, 19__, *and that death occurred at* 8:55 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 443 MD
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 6 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Aug. 5, 1969
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Twin Falls, Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Aug. 8, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO.: E-496
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 8 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3650
Local Reg. No. 364
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Nampa
c. LENGTH OF STAY (in this place): Transit
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South East of Nampa 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Walla Walla 535
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): College Place
d. STREET ADDRESS (If rural, give location): 18 West Whittman

3. NAME OF DECEASED (Type or Print): a. (First) Frank b. (Middle) William Jesse c. (Last) Lasher

4. DATE OF DEATH (Month) (Day) (Year): August 1, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 18, 1919

9. AGE (In years last birthday): 49
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physical Therapist

10b. KIND OF BUSINESS OR INDUSTRY: Sanitarium

11. BIRTHPLACE (State or foreign country): Brainerd, Minn.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William Lasher
BIRTHPLACE: Minn.

14. MOTHER'S MAIDEN NAME: Myrtle Motney
BIRTHPLACE: So. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 468 14 1798

17. INFORMANT'S OWN SIGNATURE: X Lydia Lasher
ADDRESS: College Place Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Broken Neck — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): a Fall down Stairs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident.

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): a Home

21c. (CITY, TOWN, OR TOWNSHIP): Rural Nampa 140 (COUNTY): Canyon. (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 1 69 2.4 m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?: Fell down Stairs.

22. *I hereby certify that I attended the deceased from* Inspection Only, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Weseke (Degree or title): M.D. Coroner 583

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Entombment

24b. DATE: Aug. 6, 1969

24c. NAME OF CEMETERY OR CREMATORY: HillCrest Memorial Garden

24d. LOCATION (City, town, or county) (State): Canyon County, Idaho

DATE REC'D BY LOCAL REG.: August 7, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: W. B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 9 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 9 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3651
Local Reg. No. 368
Reg. Dist. No. 360

BIRTH NO. RECEIVED AUG 12 1969 Bureau of Vital

1. PLACE OF DEATH
a. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 14 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Hilbert	L.	Miller	August 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 23, 1887	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Plumber	Construction	Cathlamet, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel H. Miller	Missouri	Emma Gates	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW1	526 01 8506	* Robert J. Miller	Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Arteriosclerotic Heart Disease	10 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Chronic Pulmonary Emphysema	5 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Benign Prostatic Hypertrophy	10 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec 4, 1967, to Aug 2, 1969, that I last saw the deceased alive on Aug 2, 1969, and that death occurred at 8:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Nampa, Idaho	8 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	8-4-69	Mt. View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 11, 1969	Mrs. Martine Walmsley	W. B. Shepherd	473

FIRM NAME Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 2 1969

SEP 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 1 5 1973
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3652
Local Reg. No. 369
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hi-Way 19, West Of Caldwell 140

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Wilder
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Wilder Labor Camp

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Rogelio		Najera Cruz	Aug. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Mexican	Married	May 13, 1943	26				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 16		Monterey, Mexico	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hirlio Najera	Mexico	Maria Cruz Sustaita	Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-44-6221	Mario del Carmen Hernandez Najera	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Auto Accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 16	Rural 140 Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8 -2-69 11:30 PM m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Thrown out of car into water in ditch

22. *I hereby certify that I attended the deceased from* Inspection only *to* _____, *19*__, *that I last saw the deceased alive on* _____, *19*__, *and that death occurred at* 11:30 P. M. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wersh 583	M.D. Coroner	Nampa, Idaho	8-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 6, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 11, 1969	Mrs. Martine Walmsley	Kenneth E Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 4 1969 Bureau of Vital Statistics

State File No. 3653
Local Reg. No. 406
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing
d. STREET ADDRESS (If rural, give location): Marsing

3. NAME OF DECEASED (Type or Print): a. (First) Emetrio b. (Middle) c. (Last) Quintana

4. DATE OF DEATH (Month) (Day) (Year): August 2, 1969.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 14, 1885.

9. AGE (In years last birthday): 83.
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner Sheep Company of
10b. KIND OF BUSINESS OR INDUSTRY: Sheep Industry

11. BIRTHPLACE (State or foreign country): Spain

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Record not Available
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Record Not Available
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-42-2482.

17. INFORMANT'S OWN SIGNATURE: Mrs. Michael Quintana
ADDRESS: Homedale, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

203X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) multiple myeloma — 5 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes XXX No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/29/ , 19 61 *to* 8/2/ , 19 69 , *that I last saw the deceased alive on* 8/2/ , 19 69 , *and that death occurred at* 2:25P m, *from the causes and on the date stated above.*

23a. SIGNATURE: Walter Abbey M.D. (Degree or title)
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 8/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Idaho.

DATE REC'D BY LOCAL REG.: Sept. 3, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Messenbrink
LICENSE NO.: E-487
FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 8 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3654
Local Reg. No. 373
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa; c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa Route #2
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospitl 050	d. STREET ADDRESS (If rural, give location): Rural Route #2

3. NAME OF DECEASED (Type or Print)	a. (First) Gladys	b. (Middle) M.	c. (Last) Gundy	4. DATE OF DEATH (Month) Aug. (Day) 3, (Year) 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Oct. 6, 1909	9. AGE (In years last birthday): 59; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: home making	11. BIRTHPLACE (State or foreign country): Lenora, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Alva Samson	BIRTHPLACE: Nebraska	14. MOTHER'S MAIDEN NAME: Dora Arnold	BIRTHPLACE: Des Moines, Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 508-14-9619	17. INFORMANT'S OWN SIGNATURE: * [signature]	ADDRESS: Nampa	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

582X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic Glomulen Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo. Bruns

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes XXX No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/26/ *, 19*65*, to* 8/3/ *, 19*69*, that I last saw the deceased alive on* 8/3/ *, 19*69 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Richard C. Tuey MD (Degree or title) 660	23b. ADDRESS: 619 So. Canyon, Nampa, Idaho	23c. DATE SIGNED: 8-9-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug. 6, 1969	24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery	24d. LOCATION (City, town, or county): Nampa (State): Idaho
DATE REC'D BY LOCAL REG.: Aug. 14, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: Richard W. Mesenbrink	LICENSE NO.: E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 2 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED AUG 26 1969 Bureau of Vital Statistics

State File No. 3655
Local Reg. No. 392
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 14 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho State School & Hospital 052

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Box 47

3. NAME OF DECEASED (Type or Print) a. (First) KATHLEEN b. (Middle) ANN c. (Last) PUGMIRE

4. DATE OF DEATH (Month) (Day) (Year) August 3, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH November 25, 1953

9. AGE (In years last birthday) 15
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 00

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Boise, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Stella Pugmire
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Wilma Keeper
ADDRESS Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic lobular Pn. — INTERVAL BETWEEN ONSET AND DEATH: 12-24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Pulmonary Edema — 24 hrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 12% burns - arms & saddle area — 5-6 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Institution 13

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Nampa 142 Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 28, 1969 8:00PM m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR? Hot water in shower.

22. *I hereby certify that I attended the deceased from* 12-15-54, 19___, *to* 8-3-69, 19___, *that I last saw the deceased alive on* 8-3-69, 19___, *and that death occurred at* 9:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE C B Rondia 443 (Degree or title) MD

23b. ADDRESS Nampa Idaho

23c. DATE SIGNED Aug 14, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-7-69

24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. August 25, 1969

REGISTRAR'S SIGNATURE Mrs. Martin Walmsley

25. EMBALMER M. B. Shepherd

LICENSE NO. 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3656
Local Reg. No. 367
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital (05)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Route #2--Nampa
d. STREET ADDRESS (If rural, give location): Route #2, Nampa

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Anton		Sedlacek	Aug.	3	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Dec. 29, 1899	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (04)	Farming	Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Sedlacek	Czechoslovakia	Mary Posvor	Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-40-0346	Hattie Sedlacek	Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

185-X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer prostate — INTERVAL BETWEEN ONSET AND DEATH: 7 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) metastase
DUE TO (c) Pneumothorax

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-6-69	Cancer prostate	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-30-69, 19__, to 8-3-, 1969, that I last saw the deceased alive on 8-1, 1969, and that death occurred at 5:40 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Caldwell Ida.	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Aug. 7, 1969	Mt. Calvary Cemetery	Canyon County	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 8, 1969	Mrs. Martina Walmsley	Richard W. Mesenbrink	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 12 1969
FEB 10 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3657
Local Reg. No. 371
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 13 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Nampa
c. LENGTH OF STAY (In this place): 9 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route 3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Nampa
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print): a. (First) Fred b. (Middle) A. c. (Last) Bushnell

4. DATE OF DEATH: (Month) August (Day) 5, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 14, 1890

9. AGE (In years last birthday): 78
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Bridgeport, New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clayton F. Bushnell
BIRTHPLACE: New York

14. MOTHER'S MAIDEN NAME: Esther Ayres
BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 12 9792

17. INFORMANT'S OWN SIGNATURE: (X) Vesta A. Bushnell
ADDRESS: Wilder, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cardiac Decompensation
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Renal Calculus

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-29-1951, to 8-5-1969, that I last saw the deceased alive on 8-5-1969, and that death occurred at 11:00A m., from the causes and on the date stated above.

23a. SIGNATURE: Henry C. Wesche (Degree or title): M.D.
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 8-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-8-69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park,
24d. LOCATION (City, town, or county) (State): Ada County, Idaho

DATE REC'D BY LOCAL REG.: Aug. 12, 1969
REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley
25. EMBALMER: C. B. Shepherd
LICENSE NO.: 473
FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 14 1969
AUG 6 1973
JUN 17 1991

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3658
Local Reg. No. 381
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 20 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa Bureau
c. LENGTH OF STAY (In this place): 9 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 052

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 504 Lake Lowell Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jake	M.	Perkins	Aug. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 16, 1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Assistant Warehouseman 08	Idaho State School	Edgar, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Everett Perkins	Missouri	Grace Hayden	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	700 09 3415	X Edith Perkins	Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Chronic Pyelonephrit 2509	3 years.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Diabetes Mellit	20 years.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 6:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard C. Dwyer M.D.	Nampa, Idaho	8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-8-69	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 19, 1969	Mrs. Martina Walmsley	W. B. Shepherd	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH–63021

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3659
Local Reg. No. 395
Reg. Dist. No. 360

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and Rural Route No.): Caldwell
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon (41)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1210 Cleveland

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Harold	H.	Atkins	Aug. 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	March 20, 1902	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Meat Cutter 21		Ornoque, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jim Atkins	Golden, Ohio	Mary A. Wilson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-09-0417	Dora T. Atkins	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 491X Acute Respiratory Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bilateral Bullous Emphysema + — Progressive
DUE TO (c) Chronic Bronchitis — 9 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* November, 1968, *to* 6 Aug, 1969, *that I last saw the deceased alive on* 5 Aug, 1969, *and that death occurred at* 3:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Krause, 295 M.D.	Caldwell, Idaho	21 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 8, 1969	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 25, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 27 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3660
Local Reg. No. 393
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital (051)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa, Rural
d. STREET ADDRESS (If rural, give location): Route 5

3. NAME OF DECEASED (Type or Print): a. (First) Herbert b. (Middle) L. c. (Last) Corder, Sr.

4. DATE OF DEATH (Month) (Day) (Year): August 6, 1969.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: January 21, 1890.

9. AGE (In years last birthday): 79
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer (04)

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Cincinnati, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Franklin Corder
BIRTHPLACE: No Record

14. MOTHER'S MAIDEN NAME: Elizabeth Jane Horne
BIRTHPLACE: No Record.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519-10-0068A

17. INFORMANT'S OWN SIGNATURE: ✓ Marie Corder
ADDRESS: Rt. 5 Nampa, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4367 Cerebral Vascular accident
INTERVAL BETWEEN ONSET AND DEATH: 3 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-29-69, 19____, *to* 8-6-69, 19____, *that I last saw the deceased alive on* 8-6-69, 19____, *and that death occurred at* 7:15 A., *from the causes and on the date stated above.*

23a. SIGNATURE: W Mueller MD (Degree or title) 250

23b. ADDRESS: 222 East Elm, Caldwell, Idaho

23c. DATE SIGNED: 8-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 9, 1969.

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Gardens

24d. LOCATION (City, town, or county) (State): Canyon County Idaho.

DATE REC'D BY LOCAL REG.: August 25, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Marvin R. Alsip

LICENSE NO.: 515

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3661
Local Reg. No. 372
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 13 1969 Division of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): Transit
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 800 Block of 17th Ave. So.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Caldwell
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Norman
b. (Middle): L.
c. (Last): Wichman

4. DATE OF DEATH (Month) (Day) (Year): Aug. 6, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 5, 1930

9. AGE (In years last birthday): 39
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Paul H. Wichman
BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Edith Kuehn
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 507 32 2574

17. INFORMANT'S OWN SIGNATURE: X Wilma C Wichman
ADDRESS: Caldwell

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Inspection & Autopsy, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:45Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche, 583 M. D. Coroner

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 8-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-11-69

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Aug. 12, 1969

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: M. B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 8 1984

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUN 8 1989

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3662
Local Reg. No. 389
Reg. Dist. No. 360

RECEIVED AUG 26 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 18 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital 052

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): 620 Pearl Street

3. NAME OF DECEASED (Type or Print)
a. (First): Thomas
b. (Middle): Dwayne
c. (Last): Holmquist

4. DATE OF DEATH (Month) (Day) (Year): August 7, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: September 1, 1950
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 50
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter D. Holmquist — BIRTHPLACE: Montana
14. MOTHER'S MAIDEN NAME: Doris W. Nodland — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Wilma Keyser — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH 485X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cachexia
DUE TO (c): severe mental retardation — birth

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-6-69, 19__, *to* 8-7-69, 19__, *that I last saw the deceased alive on* 8-7-69, 19__, *and that death occurred at* 8:00 P*m., from the causes and on the date stated above.*

23a. SIGNATURE: Eugene M Brown MD 898 (Degree or title)
23b. ADDRESS: 619 So Canyon
23c. DATE SIGNED: 8/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county): Wallace (State): Idaho

DATE REC'D BY LOCAL REG.: August 25, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Roy W. Sinigiani
LICENSE NO.: E-496

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3663
Local Reg. No. 385
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
AUG 22 1969

1. PLACE OF DEATH
a. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
c. LENGTH OF STAY (In this place) 22 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route 5

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
d. STREET ADDRESS (If rural, give location) Route 5

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) A.
c. (Last) McDonald

4. DATE OF DEATH (Month) (Day) (Year) Aug. 7, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Dec. 2, 1884
9. AGE (In years last birthday) 84
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmner
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alex McDonald
BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Mary McDonald
BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Gene Robertson
ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* August, 1969, *that I last saw the deceased alive on* July 24, 1969, *and that death occurred at* 9:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] M.D. (Degree or title)
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 8/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-11-69
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) Nampa, Idaho (State)

DATE REC'D BY LOCAL REG. August 21, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER M. B. Shepherd
LICENSE NO. 473

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 22 1969

APR 26 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3664
Local Reg. No. 376
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 19 1969

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050	d. STREET ADDRESS (If rural, give location) Route #4 Nampa

3. NAME OF DECEASED (Type or Print)	a. (First) HERBERT	b. (Middle) W.	c. (Last) STICKNEY	4. DATE OF DEATH	(Month) 8 (Day) 8 (Year) 69
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 2, 1875	9. AGE (In years last birthday) 94	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Chippewa Falls, Wisconsin	12. CITIZEN OF WHAT COUNTRY? U. S. A,		
13. FATHER'S NAME Leonard Stickney	BIRTHPLACE Maine	14. MOTHER'S MAIDEN NAME Vesta Oliver	BIRTHPLACE Maine		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-44-5525-T	17. INFORMANT'S OWN SIGNATURE Lois E. Stickney	ADDRESS Nampa		

4319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [ ] No [X]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 12 1968, *to* August 8, 1969, *that I last saw the deceased alive on* August 8, 1969, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 766 (Degree or title)	23b. ADDRESS 824-17th Ave S Nampa	23c. DATE SIGNED 8/13/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 12, 69	24c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Gardens	24d. LOCATION (City, town, or county) Canyon (State) Idaho
DATE REC'D BY LOCAL REG. August 18, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER [signature]	LICENSE NO. E496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3665
Local Reg. No. 375
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 19 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Canyon 42

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa Bureau

c. LENGTH OF STAY (In this place): 34

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor Nursing Home 307

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Canyon 42

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa

d. STREET ADDRESS (If rural, give location): Midland Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	C.	Ahrens	August 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Aug. 21, 1883	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired farmer 04	farming	Mankato, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry C. Ahrens	Germany	Lucinda Harrison	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-12-1503A	Ralph A Ahrens	Nampa

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Myocardial Infarction	1-2 hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute Coronary occlusion	2-4 days
DUE TO (c)	Coronary Atherosclerosis	20 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Residual Left Hemiparesis	10 yrs
	Markedly adv. P.V. & C.V. Disease	20 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March, 1969, *to* 9 Aug, 1969, *that I last saw the deceased alive on* 9 Aug, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C B Riordan 443 MD	Nampa Idaho	14 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 13, 1969	Cloverdale Cemetery	Ada County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 18, 1969	Mrs. Martinal Walmsley	[signature] FIRM NAME: Alsip Funeral Chapel	E-496

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3666
Local Reg. No. 382
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital (057)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon (41)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 822 Everett St.

3. NAME OF DECEASED (Type or Print): a. (First) Elva; b. (Middle) N.; c. (Last) Courtright

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Feb. 13, 1913

9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wilder, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Daugherty
BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Myrtle E. Ford
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-20-1938

17. INFORMANT'S OWN SIGNATURE: x Dolores Hazeltine
ADDRESS: Baker-Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5684

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) shock. pneumonia. atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) peritonitis — 12 DAYS
DUE TO (c) intest. obstruction — 17 DAYS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 23 JUL 69 — 28 JUL 69

19b. MAJOR FINDINGS OF OPERATION: LYSIS intestinal adhesions + peritonitis occlusion LT. iliac art. ε plaque

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 24 FEB, 1969, *to* 9 AUG, 1969, *that I last saw the deceased alive on* 9 AUG, 1969, *and that death occurred at* 10:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. Arentzen M.D. (301)

23b. ADDRESS: 222 E. Logan

23c. DATE SIGNED: 14 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 12, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: August 19, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Rodney W. Dakan — LICENSE NO.: E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 21 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 27 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3667
Local Reg. No. 374
Reg. Dist. No. 360

RECEIVED AUG 19 1969 Bureau

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
c. LENGTH OF STAY (in this place): 19 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 2 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
d. STREET ADDRESS (If rural, give location): Route # 2

3. NAME OF DECEASED (Type or Print)
a. (First): Viola
b. (Middle): D.
c. (Last): Nichols

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 10, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months 6, Days 29 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Clayton, Georgia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Logan York — BIRTHPLACE: Clayton, Georgia
14. MOTHER'S MAIDEN NAME: Rachael Hopper — BIRTHPLACE: Clayton, Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Lee Nichols — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Coronary sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 9, 1969, *to* Aug 9, 1969, *that I last saw the deceased alive on* Aug 9, 1969, *and that death occurred at* 7 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 166 — **23b. ADDRESS**: Caldwell Ida — **23c. DATE SIGNED**: 9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-13-1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Aug. 18, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 11 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG 19 1969
Bureau of V S

Certificate of Death

STATE OF IDAHO

State File No. 3668
Local Reg. No. 377
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 1, Box 56

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Tom	Taisuke	Nishioka	Aug. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Japanese	Married	May 7, 1885	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04		Hiroshima Ken, Japan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nobukichi Nishioka	Japan	Masuye Okabe	Japan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-40-5975	Tahiro Nishioka	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CANCER of RT LUNG — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Possible Myocardial infarction 1 wk.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1969, *to* Aug 9, 1969, *that I last saw the deceased alive on* Aug 9, 1969, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Donald Lowe MD 427 (Degree or title)	Caldwell Ida	8/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 12-1969	Middleton Cemetery	Middleton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 18, 1969	Mrs Martin Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

State File No. 3669
Local Reg. No. 378
Reg. Dist. No. 360

BIRTH NO.

AUG 19 1969

Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 651

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1015 Albany

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): W.
c. (Last): Schnase

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 26, 1909
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 60
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gove County, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Schnase — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Robert S Schnase — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MULTIPLE EMBOLI & THROMBI — INTERVAL BETWEEN ONSET AND DEATH: 10 d.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) MARATIC ENDOCARDITIS — 10 d.
DUE TO (c) CANCER of RT LUNG — 2-3 mos.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from approx Aug 1, 1969, to Aug 9, 1969, that I last saw the deceased alive on Aug 9, 1969 and that death occurred at 1:30 P m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald D Price 424 M.D.
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 8/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Garden
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: August 18, 1969
REGISTRAR'S SIGNATURE: Mrs. Martha Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-508

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3670
Local Reg. No. 379
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
AUG 20 1969
Bureau of V...

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 535 Sunset Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Henry	L.	High	August	11	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Dec. 23, 1887	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Carman 10	Railroad	Kansas	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marian Richard High	K ansas	Susannah Boyer	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	700-09-3394	x Frank E Falk	917 State St

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Min. to Hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASVD — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition, Electrolyte imbalance — ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jm Johnson, MD	415	1223 7th St. So. - Nampa	8/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/14/1969	Cloverdale Memorial Park	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 19, 1969	Mrs. Martina Walmsley	Marvin R. Hibbs	515

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
AUG 20 1969
Bureau of Vital

State File No. 3671
Local Reg. No. 380
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, c. LENGTH OF STAY (In this place) 1 year	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050	d. STREET ADDRESS (If rural, give location) Alpine Trailer Court, Route #5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LISLE	M.	PARKER	8	10	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
F.	W.	Widowed	May 5, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Beautician 21	Beauty	Cando, No. Dakota	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herbert Duell	Illinois	Edith Valikett	Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	540-28-0594	Robert C Flock	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/8/69, 19___, *to* 8/10/69, 19___, *that I last saw the deceased alive on* 8/9/69, 19___, *and that death occurred at* 8 00 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J B Marcusen 326	Dup	Nampa Idaho	8/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	8/13/69	Hillcrest Memorial Gardens	Canyon	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 19, 1969	Mrs. Martina Walmsley	Joe W Sinigiani	E496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3672
Local Reg. No. 414
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN: Caldwell
c. LENGTH OF STAY IN THIS PLACE: 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): Payette Auto Court

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Allen	Wyatt	Curtis	Aug. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 29, 1898	70	7	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auto Court Operator	Self	Silver City, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Van S. Curtis	Missouri	Mary Jane Wyatt	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	543-26-2209	Mrs Byron Boles	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Anterior myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-30-69, 19__, *to* 8-12-69, 19__, *that I last saw the deceased alive on* 8-12-69, 19__, *and that death occurred at* 11:39A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Reed 379	M.D.	222 East Elm, Caldwell, Idaho	8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-15-1969	ValleyView Cemetery	Vale, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3673
Local Reg. No. 384
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 22 1969 STATE OF IDAHO
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (27)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Hospital (05)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon (38)
b. COUNTY: Malheur (533)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ontario
d. STREET ADDRESS (If rural, give location): Route #1 Box 242

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Otto	Carl	Holladay	Aug	12	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	January 8 1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher Retired (04)
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Rochester, Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joe Holladay — BIRTHPLACE: UNK.
14. MOTHER'S MAIDEN NAME: Ella Early — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 540-40-9077 A
17. INFORMANT'S OWN SIGNATURE: Earl Holladay Sr. ADDRESS: Ontario

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary insufficiency
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generally deteriorated

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-64, 1962, *to* 8-12, 1969, *that I last saw the deceased alive on* 8-11, 1969, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Caldwell Ida	8-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-15-69	Evergreen	Ontario Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 21, 1969	Mrs Martina Walmsley	John A. Liemkaemper	ORE 226

FIRM NAME: Bertelson-Liemkaemper

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 8 1969

State File No. 3674
Local Reg. No. 383
Reg. Dist. No. 360

RECEIV

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 20 1969

Bureau

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print)
a. (First): Ira
b. (Middle): Doane
c. (Last): McKinnis

4. DATE OF DEATH (Month) (Day) (Year): August 12, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 6, 1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lyons, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James W. McKinnis — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Myrtle Hollinger — BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-07-5340A
17. INFORMANT'S OWN SIGNATURE: Doris M. McKinnis — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1541

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 HR

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): carcinomatosis — 1 YR
DUE TO (c): CA Rectum — 5 1/2 YR

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19 DEC 63
19b. MAJOR FINDINGS OF OPERATION: CANCER AND RECTAL JUNCTION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* SEPT, 1963, *to* 12 Aug, 1969, *that I last saw the deceased alive on* 12 Aug, 1969, *and that death occurred at* 6:05 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Montgo 367 M.D.
23b. ADDRESS: 222 E. Logan
23c. DATE SIGNED: 14 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: August 19, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: James R. Dakan
LICENSE NO.: E-485

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3675
Local Reg. No. 386
Reg. Dist. No. 360

BIRTH NO. 69-8072

RECEIVED AUG 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY IN THIS PLACE: 9 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon (4)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Caldwell Memorial Hosp.

3. NAME OF DECEASED (Type or Print): a. (First) Katherine; b. (Middle); c. (Last) Grassl

4. DATE OF DEATH: (Month) Aug. (Day) 13, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Aug. 13, 1969

9. AGE (In years last birthday): IF UNDER 1 YEAR — Months; Days. IF UNDER 24 HRS. — Hours: 9; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Or

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lawrence Grassl — BIRTHPLACE: Portland, Ore.

14. MOTHER'S MAIDEN NAME: Carol Hall — BIRTHPLACE: Weiser, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Lawrence Grassl — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

7769

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neonatal atelectasis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) M.D.

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-14-1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Aug. 22, 1969

REGISTRAR'S SIGNATURE: Mrs Martina Walmsley

25. EMBALMER: [signature]

LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can ~~issue a burial or removal permit ONLY~~ after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3676
Local Reg. No. 394
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakley's Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 917 E. Linden

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	J.	McDonald	Aug. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	Jan. 29, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CD		Siloam Springs, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wm. J. McDonald	Georgia	Mary M. Bullard	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-2241	Emmett E. Armstrong	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Insufficiency — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Superimposed pneumonitis — 3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1967, *to* 13 Aug, 1969, *that I last saw the deceased alive on* 4 Aug, 1969, *and that death occurred at* 8:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Krame, M.D.	Caldwell, Idaho	21 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 15, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 25, 1969	Mrs. Martin Walmsley	Rodney W. Dokan	F-508

FIRM NAME: Dokan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3677
Local Reg. No. 387
Reg. Dist. No. 360

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142 AUG 26 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor Nursing Home 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Alice
b. (Middle) Sarah
c. (Last) Rose

4. DATE OF DEATH (Month) (Day) (Year) Aug. 13, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 20, 1885
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) oc
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Laurel Springs, North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alex Cox — BIRTHPLACE North Carolina
14. MOTHER'S MAIDEN NAME Martha Osborn — BIRTHPLACE North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-2190
17. INFORMANT'S OWN SIGNATURE Arnold R. Rose — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*	(a) Acute Myocardial Infarction	2 days
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Bronchogenic pneumonia	4 days
	DUE TO (c) Coronary atherosclerosis	30 yrs.
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Marked by advanced, P.V. + C.V. Disease	30 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19 Oct, 1964, *to* 13 Aug, 1969, *that I last saw the deceased alive on* 12 Aug, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 443 (Degree or title) MD
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 18 Aug '69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 22, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER [signature]
LICENSE NO. E-485

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 5 - 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3678
Local Reg. No. 410
Reg. Dist. No. 360

BIRTH NO. SEP 4 1969

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): I.O.O.F. Home 195

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): I.O.O.F. Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Frances	M.	Smith	8	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	widowed	6/6/1871	98				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Berketville, California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mathew Mitchell — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Mary Ashley — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ralph W. Riggs — ADDRESS: Santa Cruz, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4867

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible] — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb, 1962, *to* Aug, 1969, *that I last saw the deceased alive on* Aug 12, 1969, *and that death occurred at* 5:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] MD	Caldwell Idaho	8/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
rem-burial	8/18/69	Hillcrest Cmetery	Weiser, Washington, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3, 1969	Mrs. Martina Walmsley	[illegible]	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3679
Local Reg. No. 409
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH — SEP 4 1969 — Bureau of Vital Statistics

a. COUNTY: Canyon 141

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital OS

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Canyon 141

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

d. STREET ADDRESS (If rural, give location): 816 Belmont

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Roy	Thomas	Westbrook	Aug. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Nov. 24, 1894	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer OS		Columbus, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Bert Westbrook		Nellie O'Conner	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	War I 3	506-10-4203A	x Mrs Maude Westbrook	

4310

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis (cerebral)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Hypertension, Diabetis mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-15-64, 19___, *to* 8-13-69, 19___, *that I last saw the deceased alive on* 8-13-69, 19___, *and that death occurred at* 9:05P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Beck MD 379	222 East Elm, Caldwell, Idaho	8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 3680
Local Reg. No. 398
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon — SEP 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Route #1 Nampa
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Myron	W.	Bradley	August 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	June 30, 1883	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Farming	Atlanta, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
No Record	No Record	No Record	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		x Oscar H. Bradley	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cerebral Vascular. — 4 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-30-65, 19____, *to* 8-14-69, 19____, *that I last saw the deceased alive on* 8-14-69, 19____, *and that death occurred at* 1:40 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Robert E. Gray MD (Degree or title)	619 So. Canyon St, Nampa, Ida	8-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 16, 1969	Terrace Lawn Cemetery	Ada County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 29, 1969	Mrs. Martina Walmsley	Marvin R. Alsip	515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3681
Local Reg. No. 396
Reg. Dist. No. 360

RECEIVED AUG 28 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2814 Virginia Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Calvin	Jay	Gould	Aug. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 23, 1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant 08	State Of Idaho	Lakeside, Calif.	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Gould	Deer Trail, Colo.	Lila Daniels	Spear Fish, So. Da.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	516-22-6635	X Mary N Gould	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardio Vascular Collapse — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Myocardial Infarction — 30 min
DUE TO (c) Atherosclerotic Heart Disease — 5 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8-15-69, 19__, to __, 19__; ~~that I last saw the deceased alive~~ on 8-15, 1969, and that death occurred at 0:15 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	222 E Logan - Caldwell	8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 20, 1969	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 27, 1969	Mrs. Martina Walmsley	John L Wilkerson	E-435

FIRM NAME: McBratney-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 9 1969
SEP 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 21 1979

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3682
Local Reg. No. 412
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH SEP 4 1969

a. COUNTY Canyon 141

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hosp. 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY Owhyee 370

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale

d. STREET ADDRESS (If rural, give location) City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Leslie	Tidwell	Aug.	15,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	9-9-1898	70	9	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.P.R. Railroad 10	Retired	Wellington, Utah	USA

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
William J. Tidwell-Mt. Pleanant, Utah	Emma C. Jones- Salt Lake City, Uta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No	518-14-0157	X William D. Tidwell

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture of (R) humerus, Hypertension — 4 day

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES XX NO

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 06	Marsing-Homedale Junction, Canyon, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK	NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
8-11-69, About 1 P.M.		XX	Automobile Accident

22. *I hereby certify that I attended the deceased from* 8-11-69, 19___, *to* 8-15-69, 19___, *that I last saw the deceased alive on* 8-15-69, 19___, *and that death occurred at* 10:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Reed M.D. 379	222 East Elm, Caldwell, Idaho	8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-19-1969	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3683
Local Reg. No. 390
Reg. Dist. No. 360

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Rt. 4
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 4

3. NAME OF DECEASED (Type or Print)
a. (First): Clarence
b. (Middle): Clifford
c. (Last): Milburn

4. DATE OF DEATH (Month) (Day) (Year): Aug. 17, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 18, 1904
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Milburn — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Martha Duncan — BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-18-7226
17. INFORMANT'S OWN SIGNATURE: Orville R. Milburn — ADDRESS:

4409

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cardiac Decompensation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection only *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 12:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wesche 583 4 M. D. Coroner
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 8-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Knowlton Heights
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: August 25, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 26 1969 Bureau of Vital Statistics

State File No. 3684
Local Reg. No. 388
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Rural
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route 3--Bowmont Community

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa-Rural
d. STREET ADDRESS (If rural, give location) Rt. 3 Bowmont Community.

3. NAME OF DECEASED (Type or Print)
a. (First) Richard
b. (Middle) V.
c. (Last) Keim

4. DATE OF DEATH (Month) (Day) (Year) August 18, 1969.

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 30, 1901
9. AGE (In years last birthday) 68 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Packer and Cattlemen
10b. KIND OF BUSINESS OR INDUSTRY Meat Packing
11. BIRTHPLACE (State or foreign country) Lodoga, Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME H.H.Keim BIRTHPLACE Sumerset, Penn.
14. MOTHER'S MAIDEN NAME Emma Harshbarger BIRTHPLACE Lodoga, Indiana.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-6282
17. INFORMANT'S OWN SIGNATURE X Minnie E. Keim ADDRESS Rt. 3 Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No XXX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-9- *, 19*69*, to* 8-18-69 *, 19____, that I last saw the deceased alive on* 8-17-1969 *, 19____, and that death occurred at* 8:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 8-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 21, 1969
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Mausoleum
24d. LOCATION (City, town, or county) (State) Canyon County, Idaho.

DATE REC'D BY LOCAL REG. August 25, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER [signature]
LICENSE NO. E-496

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 8 1969

SEP 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 1 7 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED AUG 26 1969 Bureau of Vital Statistics

State File No. 3685
Local Reg. No. 391
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, 1003-11th Ave. N.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1003-11th Ave. N.

3. NAME OF DECEASED (Type or Print): a. (First) Esther; b. (Middle); c. (Last) Baber

4. DATE OF DEATH (Month) (Day) (Year): August 19, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 8, 1917

9. AGE (In years last birthday): 52
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Picabo, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert White
BIRTHPLACE: Virginia

14. MOTHER'S MAIDEN NAME: Eva Branscome
BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-24-4728

17. INFORMANT'S OWN SIGNATURE: x Ray Baber
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute myocardial Infarction

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Inspection only *, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at* 4:00 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche 583 M. D. Coroner

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 8-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 22, 1969

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: August 25, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Richard N. Grant

LICENSE NO.: E-500

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 3 1969

Bureau of Vital Statistics

State File No. 3686
Local Reg. No. 404
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor Nursing Home 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Oregon 38
b. COUNTY: 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elgin
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Earl; b. (Middle) Cornelious; c. (Last) Kincheloe

4. DATE OF DEATH (Month) (Day) (Year): Aug. 19, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 10, 1883

9. AGE (In years last birthday): 85
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): or

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chetopa, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Kincheloe
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Sarah
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 510-01-3746A

17. INFORMANT'S OWN SIGNATURE ADDRESS: [signature]

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

600X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pyelonephritis

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic prostatic enlargement 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3-25, 19 69, *to* 8-19, 19 69, *that I last saw the deceased alive on* Aug 15, 19 69 *and that death occurred at* 5:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Marvin E Bloss (Degree or title) MD

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 23, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 2, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: [signature]

LICENSE NO.: E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 2 1969 Bureau of Vital Statistics

State File No. 3687
Local Reg. No. 397
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho 13 b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell; c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051	d. STREET ADDRESS (If rural, give location): 1818 Fillmore St.

3. NAME OF DECEASED (Type or Print) a. (First): Rose	b. (Middle): Elisabeth	c. (Last): Wheeler	4. DATE OF DEATH (Month) (Day) (Year): August 19, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: April 4, 1881	9. AGE (In years last birthday): 88; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baker, Oregon	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Edwin Beers	BIRTHPLACE: Iowa	14. MOTHER'S MAIDEN NAME: Elisabeth Cassidy	BIRTHPLACE: Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-54-0862	17. INFORMANT'S OWN SIGNATURE: Elaine W. Blomquist	ADDRESS:	

5321

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 5d

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): perforated duodenal ulcer — 5d

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 15 August, 1969, *to* 19 August, 1969, *that I last saw the deceased alive on* 19 August, 1969, *and that death occurred at* 6:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gerald R. Holcomb M.D. 860	23b. ADDRESS: Caldwell, Idaho	23c. DATE SIGNED: 8-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug. 22, 1969	24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery	24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Aug. 29, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: James R. Dakan	LICENSE NO.: E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3688
Local Reg. No. 416
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (41) — SEP 5 1969
b. CITY OR TOWN: Caldwell — LENGTH OF STAY (in this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Caldwell Memorial Hosp. (057)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Canyon (140)
c. CITY OR TOWN: Meridian
d. STREET ADDRESS (If rural, give location): P.O. Box 234

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Walter	Lee	Hight	August 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	Feb. 21, 1945	24	5	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction Laborer	Morrison-Knudson	Portland, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Hight	Utah	Lena Coley	Hayden, Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Mrs. Lena Hight	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	PULMONARY INSUFFICIENCY	12 hr.
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	PULMONARY CONTUSION, MULTIPLE RIB FRACTURE	12 hr.
DUE TO (c)	BEING STEPPED ON BY A BRAHMA BULL	12 hr.
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Severe Contusion & Fibrosis Left Lung	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (142) (STATE)
ACCIDENT	RODEO ARENA	CALDWELL, CANYON, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug 8 69 9:30 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	RODEO CONTESTANT STEPPED ON BY BULL

22. *I hereby certify that I attended the deceased from* Aug 8, 19 69, *to* Aug 20, 19 69, *that I last saw the deceased alive on* Aug 20, 19 69, *and that death occurred at* ——— m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald D. Price	M.D.	Caldwell Idaho	8/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial		Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 8 1969

FEB 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3689
Local Reg. No. 408
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Canyon — SEP 4 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE: Idaho — b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell,
d. STREET ADDRESS (If rural, give location): 313 Grant St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ida		Gooch	Aug. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	March 26, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
02		Alto, Tennessee	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harrison G. Garner		Tenessee B. Pearson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	511-01-8195B	x Paul Gooch	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5621

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive G.I hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diverticulosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Aortic stenosis with congestive failure

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-11-69, 19____, *to* 8-21-69, 19____, *that I last saw the deceased alive on* 8-21-69, 19____, *and that death occurred at* 12:20A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Reed MD 379	222 East Elm, Caldwell, Idaho	8-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 25, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr Reed

Certificate of Death

STATE OF IDAHO

State File No. 3690
Local Reg. No. 413
Reg. Dist. No. 360

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 9 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1906 1st Ave So.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Jno	Thomas	Hanigan	August	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Sept. 19, 1897	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Dealer 22
10b. KIND OF BUSINESS OR INDUSTRY: Auto
11. BIRTHPLACE (State or foreign country): Akron, Nebraska
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James H. Hanigan — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Elizabeth Hayden — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 519-36-1903
17. INFORMANT'S OWN SIGNATURE: R H Hanigan — ADDRESS: 2066 3rd Ave N - Payette

4938

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Con pulmonale — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-8-69, 19___, *to* 8-22-69, 19___, *that I last saw the deceased alive on* 8-22-69, 19___, *and that death occurred at* 8:20P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Charles E Reed M.D. 379 (Degree or title)
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 8-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-25-69
24c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery
24d. LOCATION (City, town, or county) (State): Ontario, Malheur Oregon

DATE REC'D BY LOCAL REG.: Sept. 3, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Donald F Brown
LICENSE NO.: E-408
FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 23 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3691
Local Reg. No. 403
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 SEP 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital 050

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1304 4th. St. North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	KING	J.	HARLOW		8	22	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
M	White	Married	Aug. 5, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Rail Roader 10	Rail Road	Bristol, Virginia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John W. Harlow	Virginia	Louise Horn	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		X Edith M. Harlow	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardio pulmonary arrest

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart disease
pleural effusion. Post T.U.R.P.
DUE TO (c) Pneumonitis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Urinary tract complete obstruction

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		Nampa, Idaho	Canyon	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
10 p.m. 8-21-69 m.	not at work	Result of protracted post operative period.

22. *I hereby certify that I attended the deceased from* 10 p.m. 8-21, 19 69 *to* 8-22-, 19 69, *that I last saw the deceased alive on* 8-22-, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S. Lisk 883 MD	Nampa, Idaho	8-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	8/26/69	Kohlerlawn Cemetery	Nampa Canyon	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 2, 1969	Mrs. Martina Walmsley	Marvin O. Heikkila	515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

MAR 2 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 8 1969 Bureau of Vital Statistics

State File No. 3692
Local Reg. No. 417
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051	d. STREET ADDRESS (If rural, give location) 620 Elgin

3. NAME OF DECEASED (Type or Print) a. (First) Mary	b. (Middle) E.	c. (Last) Sears	4. DATE OF DEATH (Month) (Day) (Year) Aug. 22, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 12, 1924	9. AGE (In years last birthday) 45 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) or	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sidney, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James I. Wiles	BIRTHPLACE Missouri	14. MOTHER'S MAIDEN NAME Cora Robinson	BIRTHPLACE Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 364-32-8603	17. INFORMANT'S OWN SIGNATURE Ralph Sears	ADDRESS	

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 24 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/21/69, 19 , *to* 8/22, 1969, *that I last saw the deceased alive on* 8/22, 1969, *and that death occurred at* 12:10 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE Gerald C. Bauman 034 (Degree or title) M.D.	23b. ADDRESS 1819 Ellis Caldwell	23c. DATE SIGNED 8/2/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment 4	24b. DATE Aug. 26, 1969	24c. NAME OF CEMETERY OR CREMATORY Hillcrest Mausoleum	24d. LOCATION (City, town, or county) (State) Caldwell, Idaho
DATE REC'D BY LOCAL REG. Sept. 5, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER [signature]	LICENSE NO. E-285

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 3693
Local Reg. No. 415
Reg. Dist. No. 360

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 140 SEP 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Notus
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): R.R. Crossing, City 00

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
d. STREET ADDRESS (If rural, give location): Route # 5

3. NAME OF DECEASED (Type or Print)
a. (First): Boyd
b. (Middle):
c. (Last): Beverland

4. DATE OF DEATH: August 23, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 25, 1929

9. AGE (In years last birthday): 39 — IF UNDER 1 YEAR: Months 11, Days 28 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Feeding Livestock

10b. KIND OF BUSINESS OR INDUSTRY: Farming -Ranching

11. BIRTHPLACE (State or foreign country): Moore Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Seymour Beverland — BIRTHPLACE: Moore, Idaho

14. MOTHER'S MAIDEN NAME: Georgia Palmer — BIRTHPLACE: Carmen, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 518-38-9098

17. INFORMANT'S OWN SIGNATURE: X Loon R. Beverland — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Broken neck — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Auto- Train Accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Fractures right humerus & leg

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 26
21c. (CITY, TOWN, OR TOWNSHIP): Notus — (COUNTY): 140 Canyon — (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 23 1969 4 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Hit by train when driving across railroad

22. *I hereby certify that I attended the deceased from* Inspection only, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche 583 4 M. D. Coroner
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 8-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-27-1969
24c. NAME OF CEMETERY OR CREMATORY: Lost River Cemetery
24d. LOCATION (City, town, or county) (State): Moore, Idaho

DATE REC'D BY LOCAL REG.: Sept. 3, 1969
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: Norman C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 29 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3694
Local Reg. No. 411
Reg. Dist. No. 360

BIRTH NO.

SEP 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Notus
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 651	d. STREET ADDRESS (If rural, give location) Box 493

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	Jackson	Dennis	Aug.	23	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Jan 25,1900	69	6	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Marshall Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Dennis	Ark.	Jose Keiling	Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		466-01-3451-T	Flossil Dennis	

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction	3 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pneumonia	1 day

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr, 1969, *to* 23 Aug, 1969, *that I last saw the deceased alive on* 23 Aug, 1969, *and that death occurred at* 8 *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
R L Poulson MD 651 (Degree or title)	Caldwell Ida	27 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 27, 69	Lower Boise Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 3 1969 Bureau of Vital Statistics

State File No. 3695
Local Reg. No. 401
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) Few Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY ADA 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Kuna
d. STREET ADDRESS (If rural, give location) *********

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) S. c. (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year) Aug. 23, 1969

5. SEX Male

6. COLOR OR RACE Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH March 24, 1967

9. AGE (In years last birthday) 2
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ******N 02

10b. KIND OF BUSINESS OR INDUSTRY ******

11. BIRTHPLACE (State or foreign country) Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Bryan Johnson
BIRTHPLACE Preston, Nevada

14. MOTHER'S MAIDEN NAME Mable Humpey
BIRTHPLACE Little Valley Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE X Bryan Johnson
ADDRESS Kuna, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8531

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardio pulmonary arrest — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) massive chronic salicylaism
DUE TO (c) ingestion of salicylate containing compound (Robaxin and anacin)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes XX No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Home 32

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kuna, 010 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-23-69, a.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ home

21f. HOW DID INJURY OCCUR? ingestion

22. I hereby certify that I attended the deceased from Sat. 8-23, 1969 to 8-23-, 1969, that I last saw the deceased alive on Sat. 8-23, 1969, and that death occurred at 4:30P m., from the causes and on the date stated above.

23a. SIGNATURE [signature] 583 (Degree or title) M.D

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED 8-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 8-25-69

24c. NAME OF CEMETERY OR CREMATORY Owyhee Nevada

24d. LOCATION (City, town, or county) (State) Owyhee, Nevada

DATE REC'D BY LOCAL REG. Sept. 2, 1969

REGISTRAR'S SIGNATURE Mrs Martina Walmsley

25. EMBALMER W B Shepherd

LICENSE NO. 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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D-67-1140

Certificate of Death

STATE OF IDAHO

State File No. 3696
Local Reg. No. 422
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mtn. View Nursing Home 360

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Star
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Lelia b. (Middle) c. (Last) Longhurst
4. DATE OF DEATH (Month) Aug. (Day) 23 (Year) 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb. 16, 1883
9. AGE (In years last birthday) 86
IF UNDER 1 YR. Months 6 Days 17
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Mondovi Wisc.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Henry Dillon
BIRTHPLACE UNK
14. MOTHER'S MAIDEN NAME Sara Louise Smith
BIRTHPLACE UNK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 543-18-5085-B
17. INFORMANT'S OWN SIGNATURE Ruth Maule
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive Cerebrovascular occlusion — INTERVAL BETWEEN ONSET AND DEATH 3 1/2 Months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) with Coma - paralysis generalized

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1969, to Aug, 1969, that I last saw the deceased alive on Aug 23, 1969, and that death occurred at 8-10 P m., from the causes and on the date stated above.

23a. SIGNATURE Charles E Kenah (Degree or title) MD
23b. ADDRESS 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED 9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 27, 1969
24c. NAME OF CEMETERY OR CREMATORY Star Cemetery
24d. LOCATION (City, town, or county) Star Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 10, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Roy W. Dakan
LICENSE NO. E-508
FIRM NAME: Dakan Funeral Chapel Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3697
Local Reg. No. 400
Reg. Dist. No. 360

BIRTH NO.

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140 — SEP 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Nampa
c. LENGTH OF STAY (In this place): Transit
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Lake Lowell

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1316 2nd Street North
d. STREET ADDRESS (If rural, give location): Nampa, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) Edward b. (Middle) A. c. (Last) Berrelez Jr.

4. DATE OF DEATH (Month) (Day) (Year): Aug. 24, 1969

5. SEX: Male

6. COLOR OR RACE: Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 1, 1947

9. AGE (In years last birthday): 22 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Eagle Pass, Texas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward A. Berrelez Sr. — BIRTHPLACE: Mexico

14. MOTHER'S MAIDEN NAME: Guadalupe Andrade — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 50 6053

17. INFORMANT'S OWN SIGNATURE: X Eduardo M. Burrelez — ADDRESS: Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Drowning. Accidental.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident.

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Lake Lowell 18

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 140 Canyon. Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8- 24- 69 6:40 P. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21f. HOW DID INJURY OCCUR?: Unable To Swim-

22. *I hereby certify that I attended the deceased from* Inspection Only *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 6:40 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche 553 M.D. Coroner 4

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 8-26-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 8-27-69

24c. NAME OF CEMETERY OR CREMATORY: Eagle Pass

24d. LOCATION (City, town, or county) (State): Eagle Pass, Texas

DATE REC'D BY LOCAL REG.: Sept. 2, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: W. B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 3 1969 Bureau of Vital Statistics

State File No. 3698
Local Reg. No. 402
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 350

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1503 7th Street So.

3. NAME OF DECEASED (Type or Print) a. (First) Sherman b. (Middle) J. c. (Last) Clark
4. DATE OF DEATH (Month) (Day) (Year) August 24, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 20, 1885
9. AGE (In years last birthday) 83
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Darlington, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William J. Clark
BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Dora McCowan
BIRTHPLACE Pennsylvania
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 40 1620A
17. INFORMANT'S OWN SIGNATURE ADDRESS Mrs. Loyd Dillon Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 76 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic cerebrovascular disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 Aug, 1969, to 24 Aug, 1969, that I last saw the deceased alive on 23 Aug, 1969, and that death occurred at 2:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gerald R. Holcomb M.D. 860
23b. ADDRESS Caldwell, Idaho
23c. DATE SIGNED 8-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-27-69
24c. NAME OF CEMETERY OR CREMATORY Meridian Cemetery
24d. LOCATION (City, town, or county) (State) Meridian, Idaho

DATE REC'D BY LOCAL REG. Sept. 2, 1969
REGISTRAR'S SIGNATURE Mrs. Martin Walmsley
25. EMBALMER M. B. Shepherd
LICENSE NO. 473
FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3699
Local Reg. No. 399
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon — SEP 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 121 East State St.

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): Ann
c. (Last): Murray

4. DATE OF DEATH: (Month) 8 (Day) 24 (Year) 69

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 2-13-1889

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: same

11. BIRTHPLACE (State or foreign country): Douglas Co., Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ——— Summers
BIRTHPLACE: unk.

14. MOTHER'S MAIDEN NAME: Nancy Ella Barnes
BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-44-8567D

17. INFORMANT'S OWN SIGNATURE: X Earl L. Murray
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Blood dyscrasia, Probably Myelogenous Leukemia — 2 years

DUE TO (c): ———

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fractured hip — 5 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-11, 1967, *to* 8-24, 1969, *that I last saw the deceased alive on* 8-24, 1969, *and that death occurred at* ——— *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard C. Treiger M.D.

23b. ADDRESS: 619 S. Cowyne, Nampa Ida

23c. DATE SIGNED: 8-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 8-27-69

24c. NAME OF CEMETERY OR CREMATORY: Meridian Dist. Cemetery

24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Sept. 2, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Jack L. Green

LICENSE NO.: E-528

FIRM NAME: Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 17 1995

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 3700
Local Reg. No. 407
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY Canyon SEP 4 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Wilder Bureau of Vital Statistics c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rt. # 2 Wilder
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1/2 Mile E. 1/2 N of Wilder	d. STREET ADDRESS (If rural, give location) Rt.# 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lawton	Berry	Martin	Aug. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 1, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Farm	Landis, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henderson Martin	Unknown	Nettie Martin	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	346-16-2978	Nellie Martin	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) ~~Coronary Occlusion~~

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Inspection only & Autopsy , 19 , *that I last saw the deceased alive on* , 19 , *and that death occurred at* 8:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche, 553 M. D. Coroner	Nampa, Idaho	8-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 2, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 3, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-50

FIRM NAME: Dakan Funeral Chapel Cald., Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED SEP 9 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3701
Local Reg. No. 418
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050	d. STREET ADDRESS (If rural, give location): 236 Meffan Street

3. NAME OF DECEASED (Type or Print)	a. (First) CLARENCE	b. (Middle) R.	c. (Last) BECKWITH	4. DATE OF DEATH (Month) (Day) (Year) August 27, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: March 12, 1890	9. AGE (In years last birthday): 79 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Silver Creek, Nebraska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank James Beckwith	BIRTHPLACE: Indiana	14. MOTHER'S MAIDEN NAME: Alma Cole	BIRTHPLACE: Michigan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - -	16. SOCIAL SECURITY NO.: 519-40-1989A	17. INFORMANT'S OWN SIGNATURE: Frank R Beckwith	ADDRESS: Nampa, Idaho	

5319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	General debility	2 wks.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pulmonary emboli (Multiple) and petschial hemorrhages of brain	?
DUE TO (c)	Gastic stoma ulcer with abscess formation	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 7-31-69	19b. MAJOR FINDINGS OF OPERATION: See above	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-30-69, 19__, *to* 8-27-69, 19__, *that I last saw the deceased alive on* 8-27-69, 19__, *and that death occurred at* 3:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 41	23b. ADDRESS: Nampa, Idaho 721 Roosevelt Ave.	23c. DATE SIGNED: 9-3-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8/30/69	24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens	24d. LOCATION (City, town, or county) (State): Callwell, Idaho
DATE REC'D BY LOCAL REG.: Sept. 8, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: [signature]	LICENSE NO.: E-496

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3702
Local Reg. No. 405
Reg. Dist. No. 360

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Nampa Livestock Auction

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 556 Sunset Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Britton b. (Middle) E. (Mose) c. (Last) Barrett

4. DATE OF DEATH: (Month) August (Day) 28, (Year) 1969.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 8, 1902

9. AGE (In years last birthday): 67
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yardman
10b. KIND OF BUSINESS OR INDUSTRY: Livestock Auction

11. BIRTHPLACE (State or foreign country): Moore, Montana.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Britton Barrett BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Rose Coryell BIRTHPLACE: No Record.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 540-07-9226A

17. INFORMANT'S OWN SIGNATURE: Mrs. Thelma Barrett ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection & History *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 2:05P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wenche 583 (Degree or title): M. D. Coroner

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 8-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: August 30, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Gardens

24d. LOCATION (City, town, or county) (State): Canyon County, Idaho.

DATE REC'D BY LOCAL REG.: Sept. 3, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Richard W. Messenbrink LICENSE NO.: E-489

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 4 1963

SEP 30 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3703
Local Reg. No. 428
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051	d. STREET ADDRESS (If rural, give location) Rt. # 2

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) B.	c. (Last) Tish	4. DATE OF DEATH (Month) (Day) (Year) Aug. 29, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 24, 1885	9. AGE (In years last birthday) 83 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Olive, Nebraska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George P. Tish	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Ester E. Ensley	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-40-6800A	17. INFORMANT'S OWN SIGNATURE Olive Tish	ADDRESS	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 19 Day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Aug. 3, 1966, *to* Aug. 29, 1969, *that I last saw the deceased alive on* Aug. 29, 1969, *and that death occurred at* 3:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE W. Hubler MD (Degree or title) 250	23b. ADDRESS 222 East Elm, Caldwell, Idaho	23c. DATE SIGNED 9-10-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 2, 1969	24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery	24d. LOCATION (City, town, or county) (State) Caldwell, Idaho
DATE REC'D BY LOCAL REG. Sept. 15, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Rodney W. Dakan	LICENSE NO. E-504

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3704
Local Reg. No. 426
Reg. Dist. No. 360

BIRTH NO. SEP 16 1969

1. PLACE OF DEATH
a. COUNTY: Canyon Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
d. STREET ADDRESS (If rural, give location): Route " 2

3. NAME OF DECEASED (Type or Print)
a. (First): Willard
b. (Middle): Allen
c. (Last): Tracy

4. DATE OF DEATH (Month) (Day) (Year): August 29, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 24, 1915
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months 1, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Ida. Farmway Inc.
11. BIRTHPLACE (State or foreign country): Homedale, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: W. Frank Tracy — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Millie Butts — BIRTHPLACE: Mondamin, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-20-7122
17. INFORMANT'S OWN SIGNATURE: Mrs Myrtle Tracy — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 150X Adeno carcinoma of the esophagogastric junction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8-21-69
19b. MAJOR FINDINGS OF OPERATION: Adeno carcinoma of esophagogastric junction c̄ metastases
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 13, 1969, *to* Aug. 29, 1969, *that I last saw the deceased alive on* Aug. 29, 1969, *and that death occurred at* 8:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Charles E. Reed 379 M.D.
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-2-1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmeley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3705
Local Reg. No. 433
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 7 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blvd. Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa,
d. STREET ADDRESS (If rural, give location): 614 12th Ave. So.

3. NAME OF DECEASED (Type or Print): a. (First) Jessie b. (Middle) (nmn) c. (Last) Troyer

4. DATE OF DEATH: (Month) Aug. (Day) 30, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 11, 1881

9. AGE (In years last birthday): 87
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired L.P.N. 13

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (State or foreign country): Martin County, Wisconsin

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: W. H. Duncanson
BIRTHPLACE: Minn.

14. MOTHER'S MAIDEN NAME: Clara J. Burtch
BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 28 0586

17. INFORMANT'S OWN SIGNATURE: X Agnes V Bell
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebrovascular Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arthritis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 62 *to* Aug ____, 19 69 *, that I last saw the deceased alive on* Aug 26 *, 19* 69 *, and that death occurred at* 6:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Grayson Olson MD 115

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-4-69

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Sept. 17, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: M. B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

SEP 11 1969

State File No. 3706
Local Reg. No. 420
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, 104 Sunnyside Dr.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 104 Sunnyside Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Lewis; b. (Middle) L.; c. (Last) Hamblin

4. DATE OF DEATH (Month) (Day) (Year): Aug. 31, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 9, 1897

9. AGE (In years last birthday): 71
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Samaria, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lewis L. Hamblin
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Catherine Williams
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): War I, War II

16. SOCIAL SECURITY NO.: 519-24-7702

17. INFORMANT'S OWN SIGNATURE: Ruth C. Hayes
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

4109

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coroner Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Inspection & History *, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wenche (Degree or title): M. D. Coroner

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 3, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 10, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Rodney W. Dakan

LICENSE NO.: E-504

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 15 1969

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 4 1979
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED AUG 8 1969 Bureau of Vital Statistics

State File No. 3707
Local Reg. No. 4
Reg. Dist. No. 520-521

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou (52)
b. CITY OR TOWN: Soda Springs
(If outside corporate limits, write RURAL and give township) | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 149 West Second South (522)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Colorado (06)
b. COUNTY: Denver (555)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Denver
d. STREET ADDRESS (If rural, give location): 6250 North Federal

3. NAME OF DECEASED (Type or Print): a. (First) Paul b. (Middle) Hallett c. (Last) Shufeldt

4. DATE OF DEATH (Month) (Day) (Year): August 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married	March 31, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman (26)	Tool & Die Co.	Toledo, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Shufeldt	Ohio	Hattie Hallett	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	363-01-7459	+ Mrs. Paul H. Shufeldt	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY Ooccur?
m.		

22. *I hereby certify that I attended the deceased from* Aug 1, 1969 *to* Aug 1, 1969, *that I last saw the deceased alive on* Aug 1, 1969 *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen H. Lund 534 MD	Soda Springs, Idaho	8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/4/69	Fairview Cemetery	Soda Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-7-69	Norene Bunn	Theodore S. Allen	E370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3708
Local Reg. No. 5
Reg. Dist. No. 520-521

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH.
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs Ida.
c. LENGTH OF STAY (in this place): 1 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou Memorial Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier Idaho
d. STREET ADDRESS (If rural, give location): 413 Garfield

3. NAME OF DECEASED (Type or Print): a. (First) Eulalie b. (Middle) Page c. (Last) Teichert

4. DATE OF DEATH (Month) (Day) (Year): Aug 9, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 13, 1887
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & Retired 12
10b. KIND OF BUSINESS OR INDUSTRY: School Teacher
11. BIRTHPLACE (State or foreign country): Hinsdale, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bright — BIRTHPLACE: Mass.
14. MOTHER'S MAIDEN NAME: Ella Tiffory — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 520-36-8016
17. INFORMANT'S OWN SIGNATURE: Eulalia Langford — ADDRESS: Montpelier Ida.

4409

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis. — INTERVAL BETWEEN ONSET AND DEATH: Several yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1969, *to* Aug 9, 1969, *that I last saw the deceased alive on* 8-9, 1969, *and that death occurred at* 11:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Rennie Tigert 535 MD
23b. ADDRESS: Soda Springs Idaho
23c. DATE SIGNED: 8/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Aug 12 1969
24c. NAME OF CEMETERY OR CREMATORY: Montpelier Cemetery
24d. LOCATION (City, town, or county) (State): Montpelier Idaho

DATE REC'D BY LOCAL REG.: 8-22-69
REGISTRAR'S SIGNATURE: Norene Bunn
25. EMBALMER: Nile Matthews
LICENSE NO.: E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 26 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3709
Local Reg. No. 6
Reg. Dist. No. 520-521

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 26 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Conda
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Conda
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Charles Henry Sneddon

4. DATE OF DEATH (Month) (Day) (Year): August 16, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct. 16, 1898
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 19 accountant-retired
10b. KIND OF BUSINESS OR INDUSTRY: J.R. Simplot
11. BIRTHPLACE (State or foreign country): Diamondville, Wyoming
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Sneddon — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Mary Peterson — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 520-03-8981
17. INFORMANT'S OWN SIGNATURE: Katherine E. Gill — ADDRESS: Conda, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1955, *to* Aug 16, 1969, *that I last saw the deceased alive on* Aug 12, 1969, *and that death occurred at* 5:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Allen H. Tigert, M.D. 537
23b. ADDRESS: Soda Springs Idaho
23c. DATE SIGNED: 8/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/19/69
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Norene Bunn
25. EMBALMER: Theodore S Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3710
Local Reg. No. 2
Reg. Dist. No. 520-521

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou (SC)
b. CITY OR TOWN: Soda Springs
(If outside corporate limits, write RURAL and give township) | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou Memorial Hospital (267)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou (SC)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
d. STREET ADDRESS (If rural, give location): 280 So. Second West

3. NAME OF DECEASED (Type or Print)
a. (First) Israel
b. (Middle) Barlow
c. (Last) Smedley

4. DATE OF DEATH: (Month) August (Day) 20, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Nov. 4, 1895

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Manager (16)

10b. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (State or foreign country): Bountiful, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ernest Smedley
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mary Barlow
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.I (3)

16. SOCIAL SECURITY NO.: 519-01-6218

17. INFORMANT'S OWN SIGNATURE: Theda Smedley
ADDRESS: Soda Springs, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pyelonephritis
INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April, 1969 *to* Aug 20, 1969, *that I last saw the deceased alive on* Aug 19, 1969, *and that death occurred at* 12:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Allen H. Tuttle M.D.
23b. ADDRESS: Soda Springs, Ida
23c. DATE SIGNED: 8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/23/69
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: Norene Bunn
25. EMBALMER: Theodore A. Allen
LICENSE NO.: E370

FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3711
Local Reg. No. 2002
Reg. Dist. No. 470

Certificate of Death

RECEIVED
AUG 8 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 52 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1043 Almo Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Robert
b. (Middle): Holliday
c. (Last): Church

4. DATE OF DEATH (Month) (Day) (Year): Aug. 1, 1969

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 4, 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months 1, Days 27 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Law Enforcement Officer
10b. KIND OF BUSINESS OR INDUSTRY: 08
11. BIRTHPLACE (State or foreign country): Eureka, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert R. Church, BIRTHPLACE: Duckville, Tenn.
14. MOTHER'S MAIDEN NAME: Mary Catherine Nielsen, BIRTHPLACE: Spanish Fork, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 518-10-9548
17. INFORMANT'S OWN SIGNATURE: Edna Paulson Church — ADDRESS: 1043 Almo Ave. Burley

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Severe Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1½ hrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): acute Myo Cardial infarct — 3-4 days
DUE TO (c): Coronary atherosclerosis ?

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): None
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): None m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* 8-1-, 1969, *that I last saw the deceased alive on* 8-1-, 1969, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R R Hutton MD 514
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 8/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Aug 7-1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 20 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3712
Local Reg. No. 2006
Reg. Dist. No. 470

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
AUG 19 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia (161)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY IN THIS PLACE: 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka (340)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): Rural Route 5

3. NAME OF DECEASED (Type or Print): a. (First) Donald; b. (Middle) Lee; c. (Last) Bryars

4. DATE OF DEATH: (Month) Aug (Day) 4 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: October 15 1953

9. AGE (In years last birthday): 15
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student (03)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rupert Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Woodroow W Bryars — BIRTHPLACE: Moscow Kentucky

14. MOTHER'S MAIDEN NAME: Eileen E.Hoggan — BIRTHPLACE: Ririe Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY: 518-66-7045

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Mrs. Eileen E. Bryars

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Second and Third degree burns of face, head, neck, arms and trunk with smoke inhalation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19a. DATE OF OPERATION: 8-1-69

19b. MAJOR FINDINGS OF OPERATION: Tracheostomy Performed; Third Degree Burns Debrided

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Automobile

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): (06)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY: (Month) 8 (Day) 1 (Year) 69 (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Automobile Accident

22. *I hereby certify that I attended the deceased from* 8-1, 19 69, *to* 8-4, 19 69, *that I last saw the deceased alive on* 8-4, 19 69, *and that death occurred at* 4:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C Hayden Ellingham (636) M.D.

23b. ADDRESS: 2233 Overland Avenue/Burley, Ida

23c. DATE SIGNED: 8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 7 1969

24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery

24d. LOCATION (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: Aug 18 1969

REGISTRAR'S SIGNATURE: Beth A Pearson

25. EMBALMER: Charles H Parsons

LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 2 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3713
Local Reg. No. 2003
Reg. Dist. No. 470

BIRTH NO.

RECEIVED AUG 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Burley
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 2033 N. Main St.

3. NAME OF DECEASED (Type or Print): a. (First) Samuel b. (Middle) Edgar c. (Last) Grigg

4. DATE OF DEATH (Month) (Day) (Year): August 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	November 8, 1890	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Poultry Farming	Poultry	Hurricane, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel Grigg	Fillmore, Illinois	Sarah Donaldson	Fillmore, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-36-8865	Grace LeGrigg	Burley, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 12 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 1 1960, *to* August 6, 19 69, *that I last saw the deceased alive on* August 6, 1969, *and that death occurred at* 3 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John W. Davis	MD	Burley, Idaho	August 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/11/69	Cem Memorial Gardens	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 12, 1969	Bill N. Pearson	Jerry K. Lawson	E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3714
Local Reg. No. 2004
Reg. Dist. No. 470

RECEIVED
AUG 15 1969
Bureau of Vital

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 15 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn - rural
d. STREET ADDRESS (If rural, give location): 614 West 300 South

3. NAME OF DECEASED (Type or Print)
a. (First): Stella
b. (Middle): Irene
c. (Last): Blake

4. DATE OF DEATH (Month) (Day) (Year): Aug. 7, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 4, 1898
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months 4, Days 3 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bozeman, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas E. Clark — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Nellie Daughtery, — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-26-3819A
17. INFORMANT'S OWN SIGNATURE: Lois B Yocus — ADDRESS: Heyburn, Ida

3480

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Amyotrophic lateral sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 9 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 25, 1969, *to* Aug. 7, 1969, *that I last saw the deceased alive on* Aug. 7, 1969, *and that death occurred at* 3:40 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eugene [illegible] 239 M.D.
23b. ADDRESS: 1341 Overland Ave. Burley, Idaho
23c. DATE SIGNED: 8-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Paul Cemetery
24d. LOCATION (City, town, or county) (State): Paul, Minidoka Co., Idaho

DATE REC'D BY LOCAL REG.: Aug 13-69
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3715
Local Reg. No. 2009
Reg. Dist. No. 470

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia AUG 2 1 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1835 Oakley Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1835 Oakley Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Mabel
b. (Middle): M.
c. (Last): Taylor

4. DATE OF DEATH (Month) (Day) (Year): Aug. 7, 1969

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 19, 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Green Castle, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alfred F. Cook — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Rachel Snyder — BIRTHPLACE: Ringo Point, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 519-28-0495
17. INFORMANT'S OWN SIGNATURE: Ken Taylor — ADDRESS: 1411 Wyandotte Kenmo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 9, 1969, *to* 13 March, 1969, *that I last saw the deceased alive on* 13 March, 1969, *and that death occurred at* 8:00 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. B. Kircher 283 MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 15 Aug, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/11/69
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Aug 20, 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 1 0 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 1 7 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 1 3 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3716
Local Reg. No. 2005
Reg. Dist. No. 470

BIRTH NO.

RECEIVED AUG 15 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (In this place): 35 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 735 Albion Avenue 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 735 Albion Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Herbert b. (Middle) Amos c. (Last) Raymond

4. DATE OF DEATH: (Month) Aug. (Day) 8, (Year) 1969

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 22, 1904

9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months 0, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Glasgow, Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred W. Raymond, — BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Clara Nell Marrs, — BIRTHPLACE: Bear River, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 518-05-1359

17. INFORMANT'S OWN SIGNATURE: Bea Raymond — ADDRESS: Burley, Ida 735 Normal Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shot gun blast to upper neck & head — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Suicide

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home 31

21c. (CITY, TOWN, OR TOWNSHIP): Burley 161 — (COUNTY): Cassia — (STATE): Idaho

21d. TIME OF INJURY: (Month) 8 (Day) 8 (Year) 69 (Hour) Abt. 5.50 p.m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Self inflected shot gun blast

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 5.50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: C B Young 583 — (Degree or title): Coroner

23b. ADDRESS: Burley Ida ho

23c. DATE SIGNED: 8-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Aug 12, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery,

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Aug 13 1969

REGISTRAR'S SIGNATURE: Beth A. Pearson

25. EMBALMER: Ormand J Burch

LICENSE NO.: E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG 19 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3717
Local Reg. No. 2007
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 615 south 5th street

3. NAME OF DECEASED (Type or Print)
a. (First): Milton
b. (Middle):
c. (Last): Reeves

4. DATE OF DEATH (Month) (Day) (Year): August 11 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 28 1903
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired grocery store owner
10b. KIND OF BUSINESS OR INDUSTRY: 22
11. BIRTHPLACE (State or foreign country): Pierce Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ambrose Reeves — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 518-09-0529
17. INFORMANT'S OWN SIGNATURE: Robert M. Reeves — ADDRESS: Rupert Idaho

1857

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of the prostate, with Metastases (2 yrs.)

ANTECEDENT CAUSES — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Eugene W. Schwiger 239 (Degree or title) M.O.
23b. ADDRESS: 1341 Overland Burley Idaho
23c. DATE SIGNED: 5-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug 15 1969
24c. NAME OF CEMETERY OR CREMATORY: Ketchum Cemetery
24d. LOCATION (City, town, or county) (State): Ketchum Idaho

DATE REC'D BY LOCAL REG.: Aug 18, 1969
REGISTRAR'S SIGNATURE: Ruth H. Pearson
25. EMBALMER: Charles H. Persons — LICENSE NO.: E-494
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 5 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3718
Local Reg. No. 2010
Reg. Dist. No. 470

RECEIVED AUG 21 1969

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. STREET ADDRESS (If rural, give location): East 14th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Cloud	* * *	Doggett	August 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Dec. 18, 1911	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Food Processing	Orlando, Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjiman Doggett	York Town, Ind.	Gertrude Smith	Derby, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 2	518-14-1308	Verlene Doggett	Heyburn, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute renal failure	24 hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Gastrointestinal hemorrhage	1 wk
DUE TO (c)	Duodenal ulcer	15 yrs
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-10-69, 19___, *to* 8-12-69, 19___, *that I last saw the deceased alive on* 8-12-69, 19___, *and that death occurred at* 4 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Duane R. Johnson M.D.	Burley, Idaho	8-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	8/14/69	Odd Fellows Cemetery	Marshall, Oklahoma

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 20, 1969	Burt A. Pearson	Jerry K. Lawson	E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 4 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 5 1983

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3719
Local Reg. No. 2008
Reg. Dist. No. 470

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 AUG 21 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley Bureau
c. LENGTH OF STAY (in this place): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Cassia Mem. Hosp. 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
d. STREET ADDRESS (If rural, give location): 207 E. Main St.

3. NAME OF DECEASED (Type or Print)
a. (First): Arthur
b. (Middle): Glenn
c. (Last): McCardle

4. DATE OF DEATH (Month) (Day) (Year): Aug. 15, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct. 14, 1914
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer- Agriculture & Processing
10b. KIND OF BUSINESS OR INDUSTRY: 04
11. BIRTHPLACE (State or foreign country): Marshall County, W. Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles S. McCardle * BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Mary R. (Unknown) BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. 2 4299
16. SOCIAL SECURITY NO.: 233-09-1550
17. INFORMANT'S OWN SIGNATURE: Info taken from Personal effects. ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suspected heart attack

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): factory
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Burley Casia Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 15 69 m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____ *19*__ *to* _____, *19*__, *that I last saw the deceased alive on* _____, *19*__, *and that death occurred at* abt 1:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Bruce Young 583 4 Coroner
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 8/19/69
24c. NAME OF CEMETERY OR CREMATORY: Oakley Cemetery
24d. LOCATION (City, town, or county) (State): Oakley, Idaho

DATE REC'D BY LOCAL REG.: Aug 20, 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 9 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 27 1969 Bureau of Vital Statistics

State File No. 3720
Local Reg. No. 2012
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 59 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1170 Grandview Addition

3. NAME OF DECEASED (Type or Print)
a. (First): Bertha
b. (Middle): Mary
c. (Last): Bunn

4. DATE OF DEATH (Month) (Day) (Year): Aug. 16, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 19, 1901
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months 9, Days 28 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Furnace, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME / BIRTHPLACE: John Wilburn Sides, Furnace, Neb.
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Mary Isabella Moore, Furnace, Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: 519-12-5319A
17. INFORMANT'S OWN SIGNATURE / ADDRESS: Darlene B. Finstermaker 1748 Monroe Ave Burley

203X

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiple myeloma — INTERVAL BETWEEN ONSET AND DEATH: Aug 1966

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-2-69, 19__, *to* 8-16-69, 19__, *that I last saw the deceased alive on* 8-16-60, 19__, *and that death occurred at* 11:10 *P.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eugene [signature] 234
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery,
24d. LOCATION (City, town, or county): Burley, (State): Idaho

DATE REC'D BY LOCAL REG.: Aug 22 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

SEP 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3721
Local Reg. No. 2011
Reg. Dist. No. 470

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 27 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Declo - rural
c. LENGTH OF STAY (In this place): enroute
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Interstate 80 So. Salt Lake Interchange

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 139 North Grant

3. NAME OF DECEASED (Type or Print)
a. (First): LeRoy
b. (Middle): Julius
c. (Last): Anderson

4. DATE OF DEATH (Month) (Day) (Year): August 19, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Apr. 7, 1915
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months 4, Days 12 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Central, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Anderson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Sophia Bjorkland — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: 528-12-5309
17. INFORMANT'S OWN SIGNATURE: Personal Records — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3959

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Left & Right Ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Calcific Aortic Stenosis Yrs. — duration
DUE TO (c): Obesity, severe

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__ *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* abt. 2:00 am *m., from the causes and on the date stated above.*

23a. SIGNATURE: C. Bruce Young 583 4 (Degree or title): Coroner
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 23, 1969
24c. NAME OF CEMETERY OR CREMATORY: Central Cemetery
24d. LOCATION (City, town, or county) (State): Central, Caribou Co., Idaho

DATE REC'D BY LOCAL REG.: Aug 22 1969
REGISTRAR'S SIGNATURE: Beth H Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 1 8 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

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PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3722
Local Reg. No. 2016
Reg. Dist. No. 470

RECEIVED SEP 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Almo
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Howard		Brackenbury	Aug. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	White	Widowed	March 29, 1896	73	4	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Rancher	Ranching	Almo, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edwin Devalson Brackenbury,	Plain City, Utah	Matilda Ann Beacroft,	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War I	519-03-1244	Myrna Silva	Declo, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio sclerosis — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 19 68 *to* August 20 69, *that I last saw the deceased alive on* Aug 20, 19 69, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John W Davis MD	Burley Idaho	August 23 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 23, 1969	Sunny Cedar Rest Cemetery,	Almo, Cassia Co. Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 2-69	Bert A Pearson	Ormond F Burch	E-471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

DUTIES:

SEP 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3723
Local Reg. No. 2013
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH — 16 SEP 3 1969
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write township): Burley
c. LENGTH OF STAY (in this place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 711 Overland Avenue

Bureau of Vital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 711 Overland Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Felix	R.	Roman	Aug. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Mexican	Married	Feb. 22, 1912	57	6	–		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Santa Rosalia Chih, Mexico	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sarapio Roman,	Texas	Felicia Rodrequez,	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No – – – – –	453-42-8252	Virginia H Roman	711 Overland

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-17-69, 19___, *to* 8-22-69, 19___, *that I last saw the deceased alive on* 8-21-69, 19___, *and that death occurred at* 11:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Eugene R. Robinson 239 M.D.	Burley, Idaho	8-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug. 26, 1969	Riverside Cemetery	Heyburn, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 2, 1969	Burt H. Pierson	Ormand J Burch	E-471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

OCT 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3724
Local Reg. No. 2017
Reg. Dist. No. 470

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 1 hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert - rural
d. STREET ADDRESS (If rural, give location): 100 W. 375 South

3. NAME OF DECEASED (Type or Print)
a. (First): Iven
b. (Middle): Anders
c. (Last): Olsen

4. DATE OF DEATH (Month) (Day) (Year): Aug. 24, 1969

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 6, 1921
9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months 4, Days 18 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Brigham City, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Peter Olsen — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Laura Anderson — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 720-03-7757
17. INFORMANT'S OWN SIGNATURE: Darl A. Hinson — ADDRESS: RT-1 Box 79 BURLEY

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive cerebral contusions secondary to automobile accident — INTERVAL BETWEEN ONSET AND DEATH: Approx. 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ~~ACCIDENT~~ SUICIDE HOMICIDE (Specify): Automobile
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 23 69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-23, 19 69, *to* 8-23, 19 69 *that I last saw the deceased alive on* 8-23-, 19 69, *and that death occurred at* 7:32 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C Hayden Ellingham 636 MD
23b. ADDRESS: 2233 Overland Avenue, Burley, Idaho
23c. DATE SIGNED: 8-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Brigham City Cemetery
24d. LOCATION (City, town, or county) (State): Brigham City, Utah

DATE REC'D BY LOCAL REG.: Sept. 2 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch — LICENSE NO. E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 8 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 15 1969
OCT 7 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 3 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3725
Local Reg. No. 2015
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): Rt. #3 Box 318

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Dean	Mickey	August 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	Divorced	May 12, 1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Farming	Adair, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ross E. Mickey[illegible]ld	Unknown	Cora Campfield	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	* * *	518-10-6778	Lora M. Magnuson	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 19, 1969 *to* Aug 25, 1969, *that I last saw the deceased alive on* Aug 24, 1969, *and that death occurred at* 1:38 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Burley Idaho	Aug 26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	8/25/69	Firth Cemetery	Firth, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 2 1969	Ruth N. Pearson	Jerry K. Lawson	E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3726
Local Reg. No. 2014
Reg. Dist. No. 470

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH — SEP 3 1969
a. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital (CM)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia (61)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1849 Albion Ave.

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thomas	Jefferson	Sedam	August 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widower	April 3, 1879	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter (27)	Wood work.	Harlan, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Abraham Sedam	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	* * *	712-09-5179	x Thomas Sedam	Burley, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastro-intestinal Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Probable Duodenal Ulcer
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-18, 1969, *to* 8-26, 1969, *that I last saw the deceased alive on* 8-25, 1969, *and that death occurred at* 2:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (283)	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Kircher	MD	Burley, Idaho	8-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/30/69	Pleasant View Cem.	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 2, 1969	Buck N. Pearson	Jerry K. Lawson	E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3727
Local Reg. No. 2022
Reg. Dist. No. 470

BIRTH NO.

RECEIVED SEP 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Cassia (160)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Albion - rural
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Howell Canyon, Pomerelle 2 Mi. No.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock (031)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 262 Burley Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RICHARD	E.	NEWBOLD	Aug. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	married	June 2, 1925	44	2 / 25	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction		Downey, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harold Newbold	Idaho	Louise Bloxham	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War II	518-20-4625	Helen J. Newbold	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

928X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiple skull fractures & completely crushed upper body

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY) (160)	(STATE)
Accident	Forest service rd.	Rural	Cassia	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Aug 27 1969 6:30 pm		Rollover of equiptment

22. *I hereby certify that I attended the deceased from* _____, 19____ *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* apt. 6:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ray L Mitchell 583 Acting Coroner	Burley, Idaho	9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 30, 1969	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 10, 1969	Reid H. Pearson	Ormand Burch	E471

FIRM NAME McCulloch Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 12 1969
SEP 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3728
Local Reg. No. 2018
Reg. Dist. No. 470

RECEIVED SEP 8 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burley Nursing Home 290

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paul
d. STREET ADDRESS (If rural, give location): *********

3. NAME OF DECEASED (Type or Print)
a. (First): Anna
b. (Middle): Elizabeth
c. (Last): Hackman

4. DATE OF DEATH (Month) (Day) (Year): Aug. 28, 1969

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 16, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Greentownship, Ohio
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Elias Winkler - Switzerland
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Anna Louise Hauck - Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 518-09-8099
17. INFORMANT'S OWN SIGNATURE: H E Hackman — ADDRESS: Paul, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Generalized Arteriosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/18, 1963, *to* 8-27-, 1969, *that I last saw the deceased alive on* 8-27, 1969, *and that death occurred at* 1:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J R Kircher 283 VMD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 2 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 8/30/69
24c. NAME OF CEMETERY OR CREMATORY: Paul Cemetery
24d. LOCATION (City, town, or county) (State): Paul, Idaho

DATE REC'D BY LOCAL REG.: Sept. 5, 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Garth Payne
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3729
Local Reg. No. 2023
Reg. Dist. No. 470

BIRTH NO.

RECEIVED SEP 11 1969 Vital Statistics Bureau Of

1. PLACE OF DEATH
a. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 9 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 516 Birch Drive (22)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia (61)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 516 Birch Drive

3. NAME OF DECEASED (Type or Print): a. (First) Elaine; b. (Middle) Moon; c. (Last) Gruwell

4. DATE OF DEATH: (Month) August (Day) 29, (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: March 27, 1928

9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher (12)

10b. KIND OF BUSINESS OR INDUSTRY: Teaching

11. BIRTHPLACE (State or foreign country): Hayden, Arizona

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harold K. Moon — BIRTHPLACE: Mexico

14. MOTHER'S MAIDEN NAME: Marie M. Moon — BIRTHPLACE: Mesa, Arizona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): * * *

16. SOCIAL SECURITY NO.: 519-26-9491

17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Burley, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1830

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, metastatic - ovary — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-27, 1969, *to* 8-29, 1969 *that I last saw the deceased alive on* 8-29, 1969, *and that death occurred at* 7:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) — **23b. ADDRESS**: Burley Idaho — **23c. DATE SIGNED**: 9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 9/2/69 — **24c. NAME OF CEMETERY OR CREMATORY**: View Cemetery — **24d. LOCATION** (City, town, or county) (State): Cassia County, Idaho

DATE REC'D BY LOCAL REG.: Sept 10 1969 — REGISTRAR'S SIGNATURE: Ruth H. Pearson

25. EMBALMER: Jerry K. Lewis — LICENSE NO.: E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: SEP 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3730
Local Reg. No. 2019
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia — SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
c. LENGTH OF STAY (in this place): 32 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South of Town

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
d. STREET ADDRESS (If rural, give location): 202 N. Blaine

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Richard	Golden	Harper	August 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Feb. 22, 1902	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Police Chief	Law-Enforcement	Albion, Idaho	U.S.A.

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
Joseph Harper - Calls Fort, Utah	Sarah Baty - Brigham City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-09-0348	Shirley J. Halford	Burley

42299

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Natural Causes due to age — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Apparent Heart attack
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
	Rural	Rural (Oakley) Cassia Idaho	m.		

22. *I hereby certify that I attended the deceased from* _____ *19__, to* _____ *19__, that I last saw the deceased alive on* _____ *19__, and that death occurred at* Apt 1:00 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
LaMar Young 553 4 Corroner	Burley	9-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/2/69	Pleasant View	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 5 1969	Buck N. Pearson	Martha Tuttle	E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

MAR 2 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3731
Local Reg. No. 2024
Reg. Dist. No. 470

BIRTH NO.

RECEIVED SEP 11 1969 Vital Statistics Bureau of Health

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (In this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 109 F. St.

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Emory
c. (Last): Rose

4. DATE OF DEATH: (Month) August (Day) 30 (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Oct. 2, 1891

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Chester, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Rose — BIRTHPLACE: North Ogden, Utah

14. MOTHER'S MAIDEN NAME: Loretta Williams — BIRTHPLACE: North Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-01-8334-A

17. INFORMANT'S OWN SIGNATURE: Edna L Rose — ADDRESS: Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Adenocarcinoma, metastatic - stomach — INTERVAL BETWEEN ONSET AND DEATH: 9 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov. 6, 1966, *to* Aug. 30, 1969, *that I last saw the deceased alive on* Aug. 30, 1969, *and that death occurred at* 10:40 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. R. Peterson MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9/2/69
24c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
24d. LOCATION (City, town, or county) (State): Chester, Idaho

DATE REC'D BY LOCAL REG.: Sept 10 1969
REGISTRAR'S SIGNATURE: Beth M Pearson
25. EMBALMER: Jerry K. Lauer — LICENSE NO.: E-522
FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3732
Local Reg. No. 54
Reg. Dist. No. 210

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
DURATION OF STAY (in this place): 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Clearwater Valley Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): 819 Riverside Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NEIL	DAVID	SCOTT	Aug. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	married	June 9, 1901	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
painter	building	Fostin, Minn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. C. Scott	Canada	Catherine McPherson	Mich.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-24-3177	X Mrs Neil D. Scott	Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute myocardial injuries
DUE TO (c) Atrial sclerotic heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 15, 1969, *to* Aug 18, 1969, *that I last saw the deceased alive on* Aug 18, 1969, *and that death occurred at* 7:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert D. Hill, M.D.	Orofino Idaho	8-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug. 21, 69	Lewis-Clark Mem. Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 22, 1969	Lerw M. Burger	[illegible]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 21 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3733
Local Reg. No. 55
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH — AUG 27 1969
a. COUNTY (180) Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Headquarters-rural
c. LENGTH OF STAY (in this place) hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cooper Cr. Section 27 (500)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). (180)
a. STATE Idaho
b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weippe
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) GERALD b. (Middle) DEAN c. (Last) KINGEN
4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 1969
5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Jan. 24, 1941
9. AGE (In years last birthday) 28 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) woods worker (17)
10b. KIND OF BUSINESS OR INDUSTRY lumber
11. BIRTHPLACE (State or foreign country) Orofino, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter Kingen — BIRTHPLACE Wash.
14. MOTHER'S MAIDEN NAME Edith Ownbey — BIRTHPLACE Wash.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1958-1960
16. SOCIAL SECURITY NO. 519-42-4124
17. INFORMANT'S OWN SIGNATURE X Arnold Roy Kingen — ADDRESS Weippe

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral concussion, broken neck, internal injuries. — INTERVAL BETWEEN ONSET AND DEATH: Short time

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) forest (04)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (180) (STATE) headquarters, Clearwater, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 20, 69, 8a
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? hit by a falling snag

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 8:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (583) (Degree or title) Coroner
23b. ADDRESS Route 1 Orofino, Idaho
23c. DATE SIGNED 8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 8-25-69
24c. NAME OF CEMETERY OR CREMATORY Fraser
24d. LOCATION (City, town, or county) (State) Orofino, Idaho

DATE REC'D BY LOCAL REG. August 25, 1969
REGISTRAR'S SIGNATURE Lura M. Burger
25. EMBALMER
LICENSE NO. 476
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3734
Local Reg. No. 56
Reg. Dist. No. 210

BIRTH NO.

RECEIVED SEP 8 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater 30
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 51 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: New York 33
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chadwicks
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print): a. (First) LEO b. (Middle) J. c. (Last) PHILLIPSON

4. DATE OF DEATH: (Month) August (Day) 29, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 7-29-93

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hartford, New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Phillipson — BIRTHPLACE: New York

14. MOTHER'S MAIDEN NAME: Mary Dunn — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-60-9872

17. INFORMANT'S OWN SIGNATURE: Records Christine P. Lovell — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of gall bladder with extensive metastases — INTERVAL BETWEEN ONSET AND DEATH: 8 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Bowel obstruction secondary to chronic perforated appendicitis — Several months

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July 7, 1969, *to* August 29, 1969, *that I last saw the deceased alive on* August 29, 1969, *and that death occurred at* 1:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE C. A. Cleto (Degree or title) M.D.

23b. ADDRESS: Box 672, Orofino, Idaho

23c. DATE SIGNED: 8/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Sept. 3, 69

24c. NAME OF CEMETERY OR CREMATORY: Riverside

24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Sept. 5, 1969

REGISTRAR'S SIGNATURE: Lera M. Burger

25. EMBALMER: Lyle A. Gilbertson

LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 19 1969

State File No. 3735
Local Reg. No. 6
Reg. Dist. No. 680

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Custer
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
c. LENGTH OF STAY (in this place): -0-
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (in pickup truck-sudden)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): May
d. STREET ADDRESS (If rural, give location): Wagner Ranch

3. NAME OF DECEASED (Type or Print)
a. (First): Ruth
b. (Middle): Harriette
c. (Last): Wagner

4. DATE OF DEATH (Month) (Day) (Year): August 6, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 22, 1922

9. AGE (In years last birthday): 47
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cambridge, Mass.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter Edgehille-Cambridge, Mass.

14. MOTHER'S MAIDEN NAME: Be tha Wolsonhome

BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 023-16-3492

17. INFORMANT'S OWN SIGNATURE: Ruth Wagner
ADDRESS: May, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH: -0-

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Ralph Potter 583 (Degree or title): Coroner
23b. ADDRESS: Challis Ida
23c. DATE SIGNED: 8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 11, 1969
24c. NAME OF CEMETERY OR CREMATORY: May
24d. LOCATION (City, town, or county) (State): May, Idaho

DATE REC'D BY LOCAL REG.: 8-16-69
REGISTRAR'S SIGNATURE: Lavina J. Mueller
25. EMBALMER: Robert C. Jones
LICENSE NO.: E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 9 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3736
Local Reg. No. 6
Reg. Dist. No. 680

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 19 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Custer 190
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
c. LENGTH OF STAY (in this place): 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gustafson home 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): LeRoy (also Roy)
b. (Middle): Gustaf
c. (Last): Gustafson

4. DATE OF DEATH (Month) (Day) (Year): August 7, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct. 19, 1903
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Smithfield, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Gustaf Gustafson — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Yarda Johnson — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-10-3226
17. INFORMANT'S OWN SIGNATURE: Mrs. Mona James — ADDRESS: Challis, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden death due to — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Malignant Hypertension 3yr.

DUE TO (c) Coronary occlusion or 0

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Cerebral Hemorrhage 0

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 22, 1966 *to* Aug 6, 1969, *that I last saw the deceased alive on* Aug 6, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 045
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 8-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Challis
24d. LOCATION (City, town, or county) (State): Challis, Idaho

DATE REC'D BY LOCAL REG.: 8-16-69
REGISTRAR'S SIGNATURE: Pauline J. Mulder
25. EMBALMER: Delbert C. Jones — LICENSE NO. E 369

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: JONES FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3737
Local Reg. No. 5
Reg. Dist. No. 5-40

BIRTH NO.

RECEIVED
SEP 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Franklin 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
c. LENGTH OF STAY IN (this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weston
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joseph	M.	Phillips	Aug. 11 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Oct. 31, 1893	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	dry farm	Logan, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Phillips	Abergaving, England	Sarah McCann	Smithfield, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	529 10 3262	Ines L. Phillips	Weston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) ~~CORONARY OCCLUSION~~ — INTERVAL BETWEEN ONSET AND DEATH: 1 Hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leo R. Hampton 214 M.D.	Preston, Idaho	8/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 15, 1969	Weston Cemetery	Weston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-15-69	Eppie W. Brouwer	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 23 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. [ICA 38-206 and 215.] Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 2 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3738
Local Reg. No. 2
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
LENGTH OF STAY (in this place) 3 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 120 South 1st East

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 120 South 1st East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Emma	Wickham	Dunkley	Aug. 15 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Aug. 17, 1873	96				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Brigham City, Utah	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Wickham	England	Annie Maria Kjar	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-44-9936 D	Etta D. Crockett	Preston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 4 yrs
DUE TO (c) Arteriosclerosis — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-13, 1969, *to* 7-15, 1969 *that I last saw the deceased alive on* 7-14, 1969 *and that death occurred at* 1:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. B. Cutler MD	Preston Idaho	7-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1969	Whitney Cemetery	Whitney Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-18-69	Effie W. Brower	O. Sherwin Webb	316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 3739
Local Reg. No. 7
Reg. Dist. No. 540

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Franklin — SEP 2 1969

b. CITY OR TOWN: Preston

c. LENGTH OF STAY (In this place): 2 hrs

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: Franklin

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston

d. STREET ADDRESS (If rural, give location): 181 West 1st North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Julia	Wilcox	Fellows	Aug. 18 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Dec. 30, 1888	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Franklin, Idaho	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Perry	England	Mary Jane Ridges	Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-18-6482	Marjorie Hollingsworth	193 N. 1st West Preston Ida

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Coronary Occlusion	12 hours
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart disease	4 yrs
DUE TO (c)	Arteriosclerosis	8 yrs
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 17, 19 69, *to* Aug 18, 19 69, *that I last saw the deceased alive on* Aug 17, 19 69, *and that death occurred at* 1 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. R. Cullen MD	Preston Idaho	8-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 21, 1969	Preston	Preston Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-21-69	Eppie W. Brouwer	Webb Funeral Home	316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

SEP 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.. .....

Certificate of Death

STATE OF IDAHO

State File No. 3740
Local Reg. No. 8
Reg. Dist. No. 3-40

RECEIVED
SEP 2 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 21
b. CITY OR TOWN (If outside corporate limits, write RURAL) (Township) LENGTH OF STAY (In this place) Hiway 91, near Franklin, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) none 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Utah 45
b. COUNTY Cache 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Logan
d. STREET ADDRESS (If rural, give location) 1607 Saddle Hill Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RALPH	LINCOLN	JENSON	AUG. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caus	Divorced	b. 12, 1946	23				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 27	Truck-Automobiles	Logan, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clyde Jenson	Logan, Ut.	Zella Buehler	Logan, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		-	Clyde Jenson	Logan, Utah

8169

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) APPARENT INTERNAL INJURIES OF ABDOMINAL & THORAXIC CAVITY — INTERVAL BETWEEN ONSET AND DEATH: 1 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) PICK-UP ROLL OVER VICTIM
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
ACCIDENT	3 HIGHWAY 4591	NEAR FRANKLIN 21	FRANKLIN	IDAHO

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐	NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
AUG	22	69	12:30A m.			AUTO ROLL OVER VICTIM

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 12:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Douglas S Webb 583	CORONER	109 E ONEIDA PRESTON IDAHO	8/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem/Burial	Aug. 25, 1969	Logan Cem.	Logan, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-69	Eppie W Brewer	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 23 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3741
Local Reg. No. 9
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 21 Franklin — SEP 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston — LENGTH OF STAY (in this place) 50 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 255 East 2nd South

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Idaho 13 — b. COUNTY Franklin 21
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 255 East 2nd South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Dean	Wettstein	Merrill	Aug. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 19, 1913	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sub station Boreman	Power Co.	Richmond, Utah	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theo Merrill	Richmond, Utah	Anna Wettstein	Bern, Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 09 0007	Frances W. Merrill	Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Coronary Occlusion	hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-22, 1969, *to* 8-22, 1969, *that I last saw the deceased alive on* 7-22, 1969, *and that death occurred at* 6 11 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. R. Cullimore	MD	Preston Idaho	8-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 25, 1969	Whitney	Whitney Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-1969	Effie W. Brower	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3742
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

RECEIVED AUG 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 220 Fremon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Teton City
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	BLACKFORD	BRIGGS	August 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married	March 26, 1909	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 64	Self-Employed	Teton City, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George A. Briggs	Salt Lake City, Utah	Eva Blackford	Lanshire, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	518-07-6212	Emma Lee	Newdale, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4109 Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Insufficiency — 4 hrs.
DUE TO (c) Recurrent

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 12, 1969 *to* August 12, 1969, *that I last saw the deceased alive on* August 12, 1969 *and that death occurred at* 12:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	298	Rexburg - Ida.	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	16 Aug 69	Teton-Newdale Cemetery	Sugar City, RFD, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
18 Aug 69	[signature]	M. D. Hansen	E-356

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 14 1979

OCT 23 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR - 6 1982

PENALTIES: Under the Idaho law, it is a misdemeanor to

AUG 28 2015

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 29 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3743
Local Reg. No. 37
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Island Park
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at cabin on Moose Creek

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah
b. COUNTY: Weber
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ogden
d. STREET ADDRESS (If rural, give location): 435 Canyon Road

3. NAME OF DECEASED (Type or Print)
a. (First): Leonard
b. (Middle): Earl
c. (Last): CASHMORE Sr.

4. DATE OF DEATH (Month) (Day) (Year): Aug. 13, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 17, 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker
10b. KIND OF BUSINESS OR INDUSTRY: S.P. Railroad
11. BIRTHPLACE (State or foreign country): Ogden, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Manasah Cashmore — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Daisy Wardleigh — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. I
16. SOCIAL SECURITY NO.: 701014121
17. INFORMANT'S OWN SIGNATURE: X Daisy G Cashmore — ADDRESS: Ogden, Ut.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, *19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at* 7:10a *m., from the causes and on the date stated above.*

23a. SIGNATURE: Paul Connell (Degree or title): Coroner
23b. ADDRESS: Box 170, St. Anthony, Ida. 83445
23c. DATE SIGNED: 8-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem-Burial
24b. DATE: 8/16/69
24c. NAME OF CEMETERY OR CREMATORY: Ogden City Cemetery
24d. LOCATION (City, town, or county): Ogden, Utah (State)

DATE REC'D BY LOCAL REG.: 28 Aug 69
REGISTRAR'S SIGNATURE: M. L. Hansen
25. EMBALMER: Robert Q. Bean — LICENSE NO.: E456

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Robert Bean Funeral Home, Ashton, Idaho

DUTIES:

AUG 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3744
Local Reg. No. 37
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont — SEP 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): ?
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana
b. COUNTY: Gallatin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Yellowstone
d. STREET ADDRESS (If rural, give location): none given

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle): T.
c. (Last): Hoffman

4. DATE OF DEATH (Month) (Day) (Year): August 26, 1969

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 23, 1903
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): motel operator
10b. KIND OF BUSINESS OR INDUSTRY: Tourist
11. BIRTHPLACE (State or foreign country): North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel Gartner — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Louise Hursh — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Family Records — Sotkin - Nelson Fun Home — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Chronic coronary heart disease — 3 weeks

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-12, 1969, *to* 8-26, 1969, *that I last saw the deceased alive on* 8-26, 1969, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)
23b. ADDRESS: Ashton - Idaho
23c. DATE SIGNED: 9-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal for Burial
24b. DATE: Aug 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memoritl Cem
24d. LOCATION (City, town, or county) (State): Glendive, Montana

DATE REC'D BY LOCAL REG.: 15 Sept 69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Quinn Bean — Robert Bean
LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robert Bean Funeral Home

DUTIES:

SEP 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3745
Local Reg. No. 32
Reg. Dist. No. 651

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Isalnd Park, Rural
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Hiway #191 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): 42 West 2nd North

3. NAME OF DECEASED (Type or Print)
a. (First): DONNA
b. (Middle): L. RASMUSSEN
c. (Last): BURNS

4. DATE OF DEATH (Month) (Day) (Year): August 31, 1969

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 7 July 1936
9. AGE (In years last birthday): 33 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stenographer 08
10b. KIND OF BUSINESS OR INDUSTRY: A.S.C.S. office
11. BIRTHPLACE (State or foreign country): Parker, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ted Rasmussen — BIRTHPLACE: Kilgore, Idaho
14. MOTHER'S MAIDEN NAME: Jeneal Jackson — BIRTHPLACE: Parker, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-40-8113
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Parker, Ida

8129

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Fractured Skull and Internal Injuries~~ — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): U. S. Hiway 191 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Isalnd Park, Fremont, Idaho 220
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): August 31, 1969 1:05 AM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car sideswiped trailer going of road hitting trees.

22. *I hereby certify that I attended the deceased from* D.O.A. *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 1:05 AM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 583 4 Coroner
23b. ADDRESS: St. Anthony, Idaho
23c. DATE SIGNED: 3 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3 Sept 69
24c. NAME OF CEMETERY OR CREMATORY: Kilgore Cemetery
24d. LOCATION (City, town, or county) (State): Kilgore, Clark County, Idaho

DATE REC'D BY LOCAL REG.: 3 Sept 69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: M. D. Hansen — [signature]
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 9 1969

APR 12 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED SEP 11 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3746
Local Reg. No. 33
Reg. Dist. No. 651

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
LENGTH OF STAY (in this place): min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fremont General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls (Rural)
d. STREET ADDRESS (If rural, give location): Rte. #5 Thiel Road

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	VENNA	ILENE	CHASE	Aug. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	Feb. 21, 1941	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	Home	St. Anthony, Idaho.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oral M. McMinn	Idaho	Delores Brown	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No None	518-48-0446	Lloyd Chase	Rte. #5 Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary congestion (Blood)
DUE TO (c) Multiple Rib fractures

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Blood loss
Cerebral concussion, Fx femur

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway	St. Anthony Fremont Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug 31, 1969 8p m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Drive of an auto struck head-on by another car

22. *I hereby certify that I attended the deceased from* Aug 31, 1969, *to* Aug 31, 1969, *that I last saw the deceased alive on* Aug 31, 1969, *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Lloyd Barrett MD	St. Anthony, Idaho.	9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 5, 1969	Ririe-Shelton	Shelton Bonneville Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-6-69	M. D. Hansen	M. D. Hansen	E-354

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3747
Local Reg. No. 4
Reg. Dist. No. 340-34

RECEIVED AUG 8 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 385

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gem 232
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Route 1 Box 215

3. NAME OF DECEASED (Type or Print)
a. (First) Leonel
b. (Middle) Percy
c. (Last) Jones

4. DATE OF DEATH (Month) (Day) (Year) August 1, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH April 29, 1899
9. AGE (In years last birthday) 70
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckdriver 10
10b. KIND OF BUSINESS OR INDUSTRY transportation
11. BIRTHPLACE (State or foreign country) Oakland, California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leonel Percy Jones
BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Catherine Fuller
BIRTHPLACE California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 573 12 8095A
17. INFORMANT'S OWN SIGNATURE X Roberta Carr
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PROBABLE ACUTE

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) MYOCARDIAL INFARCTION

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH
DEAD ON ARRIVAL

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DEAD, 19__, *to* ARRIVAL, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Ronald P Faulkner MD
23b. ADDRESS EMMETT IDAHO
23c. DATE SIGNED 8/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Aug. 5, 1969
24c. NAME OF CEMETERY OR CREMATORY Emmett
24d. LOCATION (City, town, or county) Emmett, Idaho (State)

DATE REC'D BY LOCAL REG. Aug 6, 1969
REGISTRAR'S SIGNATURE Jean O Beatty
25. EMBALMER Glenn W Beatty
LICENSE NO. E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated AUG 8 1969 Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

p.

Certificate of Death

RECEIVED
AUG 14 1969
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3748
Local Reg. No. 5
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 3days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 501 East 4th St

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Grace	Glover	Bishop	August 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married	December 11, 1887	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Meridan, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ralph Streeter	Waterloo, Wisconsin	Viola Lavina Glover	Burnett, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-32-8799B	X Russell Bishop	Emmett Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive C-V disease — 10 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____ 19__, *to* 5 Aug, 19 69, *that I last saw the deceased alive on* 5 Aug, 1969, *and that death occurred at* 3:40A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R L Broadbent	MD	Emmett, Ida.	8 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug. 8, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 8 1969	Jean A Beatty	Glenn W Beatty	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 23 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 10 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 18 1973

OCT 25 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3749
Local Reg. No. 7
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem — SEP 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett | LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Route 2 Box 231

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Samuel	Dedrisk	Young	August 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	February 17, 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer	farm	Putnum County, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Young	Arkansas	Mathilda E. Lawson	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-42-2504	X Norman D Young	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-29 *19* 56, *to* 8-8, *19* 69, *that I last saw the deceased alive on* 5-31-69, *19*, *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harmon E. Hohenson MD	Emmett, Idaho	8-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug. 11, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 11, 1969	Jean A. Beatty	Glenn W Beatty	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 14 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3750
Local Reg. No. 6
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Mem. Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Emmett Valley Manor

3. NAME OF DECEASED (Type or Print)
a. (First): Lizzie
b. (Middle):
c. (Last): Applegate

4. DATE OF DEATH (Month) (Day) (Year): August 10, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: June 21, 1881
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months 1, Days 21 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 31
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Wyoming, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harvey Foreman — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Susanna Schanck — BIRTHPLACE: Westville, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-26-0092
17. INFORMANT'S OWN SIGNATURE: X Mrs Robert Pitman — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis & — 1 year
DUE TO (c) [illegible]

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1950, *to* Aug 10, 1969, *that I last saw the deceased alive on* Aug 10, 1969, *and that death occurred at* 7:50P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ronald P. Rawlinson HD 429
23b. ADDRESS: Emmett Idaho
23c. DATE SIGNED: Aug 11 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug 11, 1969
REGISTRAR'S SIGNATURE: Jean A Beatty
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

R

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3751
Local Reg. No.
Reg. Dist. No. 340-341

BIRTH NO.

SEP 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp. 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 436 Monroe

3. NAME OF DECEASED (Type or Print)
a. (First): Mable
b. (Middle): Bernice
c. (Last): Cooper

4. DATE OF DEATH (Month) (Day) (Year): August 25, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 15, 1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months 7, Days 10 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Warsaw, Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lewis W. Farber — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Mable May McCreary — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-10-6831B
17. INFORMANT'S OWN SIGNATURE: X Schley W. Cooper — ADDRESS

1890

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Kidney — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): c̄ metastases — 1 year
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes mellitus — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1967, *to* Aug 28, 1969, *that I last saw the deceased alive on* Aug 28, 1969, *and that death occurred at* 8:05P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ronald P. Rawlinson MD 429
23b. ADDRESS: Emmett Idaho
23c. DATE SIGNED: 8/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 28, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sweet
24d. LOCATION (City, town, or county) (State): Sweet, Idaho

DATE REC'D BY LOCAL REG.: Aug 28, 1969
REGISTRAR'S SIGNATURE: Jean A Beatty
25. EMBALMER: Glenn W Beatty — LICENSE NO. E-392
FIRM NAME: THE BEATTY CHAPEL — Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3752
Local Reg. No. 3162
Reg. Dist. No. 420

BIRTH NO.

RECEIVED AUG 21 1969

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
c. LENGTH OF STAY (in this place) 8 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
d. STREET ADDRESS (If rural, give location) South 4 and West 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Carl	Slumner	Martin	August 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	9-13-1884	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ranch 04	Farming	Salisbury, Vermont	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward H. Martin	China	Ida May Hinckley	Vermont

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-42-7346	Marjorie H. Martins	Wendell, Ida.

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Atypical pneumonia	12 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	10 yrs
DUE TO (c)	Unhealed fracture of left hip	2 yrs
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Osteoarthritis of spine	5 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__ *to* death, 19__, *that I last saw the deceased alive on* 8/7, 1969, *and that death occurred at* 9:30Am., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold G. Holsinger	M.D.	Wendell, Idaho	8-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-11-69	Wendell Cemetery	Wendell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 11, 1969	Eddie D. Leach	Joe B. Leeper	E-530

FIRM NAME: Leeper Mortuary Wendell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3753
Local Reg. No. 3163
Reg. Dist. No. 420

BIRTH NO.

RECEIVED AUG 21 1969

1. PLACE OF DEATH a. COUNTY: Gooding 240	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding Bn c. LENGTH OF STAY (In this place): 5 Hrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding County Memorial 040	d. STREET ADDRESS (If rural, give location): 533 Washington

3. NAME OF DECEASED (Type or Print)	a. (First) Nettie	b. (Middle) Jane	c. (Last) Bell	4. DATE OF DEATH (Month) (Day) (Year) August 11, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Feb. 27, 1891	9. AGE (In years last birthday): 78 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Homemaker	11. BIRTHPLACE (State or foreign country): Truce Texas	12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: William Ferguson	BIRTHPLACE: Texas	14. MOTHER'S MAIDEN NAME: Minnie Goldsmith	BIRTHPLACE: Texas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —	16. SOCIAL SECURITY NO.: 518-42-6353	17. INFORMANT'S OWN SIGNATURE: X Melvin M. Bell	ADDRESS: [illegible]	

1538

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	exsanguination	3 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	gastrointestinal hemorrhage	3 days
DUE TO (c)	carcinoma of colon	5 mon
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 Apr, 1969, *to* 11 Aug, 1969, *that I last saw the deceased alive on* 11 Aug, 1969, *and that death occurred at* 3:10 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Richard Thompson 113 (Degree or title)	23b. ADDRESS: Gooding Idaho	23c. DATE SIGNED: 19 Aug 69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug. 14, 1969	24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding Gooding Idaho		
DATE REC'D BY LOCAL REG.: 20-Aug-1969	REGISTRAR'S SIGNATURE: Edna S. Leach	25. EMBALMER: X Fred J. Nelson
LICENSE NO.: E-504		

FIRM NAME: Thompson Chapel Gooding, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 2 5 1985

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 3 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3754
Local Reg. No. 3169
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH 240
a. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
c. LENGTH OF STAY (in this place): 10 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): **********

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Andrew
c. (Last): Renner

4. DATE OF DEATH (Month) (Day) (Year): Aug. 15, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 31, 1876
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 04
10b. KIND OF BUSINESS OR INDUSTRY: Rancher
11. BIRTHPLACE (State or foreign country): Maysville, Dekalb, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Albert Renner - Harrison, Ohio
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Survilla Phelps - Maysville, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 519-03-1335A
17. INFORMANT'S OWN SIGNATURE: Ida Anderson — ADDRESS: Declo, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ant. sclerotic heart disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-21, 1968, *to* 8-15, 1969, *that I last saw the deceased alive on* 8-7, 1969, *and that death occurred at* 12:05 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice E. Scheel M.D.
23b. ADDRESS: Wendell, Idaho 83355
23c. DATE SIGNED: 8-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 8/15/69
24c. NAME OF CEMETERY OR CREMATORY: View Cemetery
24d. LOCATION (City, town, or county) (State): R.F.D. Burley, Idaho

DATE REC'D BY LOCAL REG.: Aug 30, 1969
REGISTRAR'S SIGNATURE: Eddie B. Leach
25. EMBALMER: Garth Swipe
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Payne Mortuary

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 3 1969
Bureau of Vital Statistics

State File No. 3755
Local Reg. No. 3165
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Gooding 240	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding c. LENGTH OF STAY (In this place) 18 hrs	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gooding Co. Mem. Hospital 090	d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print) a. (First) Augustin	b. (Middle)	c. (Last) Sabala	4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 5, 1899	9. AGE (In years last birthday) 70 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming --Livestock & Agriculture	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ispaster, Spain	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jose M. Zabala	BIRTHPLACE Ispaster, Spain	14. MOTHER'S MAIDEN NAME Maria I. Arhabal	BIRTHPLACE Ispaster, Spain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If yes, give war or dates of service) ---------	16. SOCIAL SECURITY NO. 518-10-8419A	17. INFORMANT'S OWN SIGNATURE X Raymond Sabala	ADDRESS Twin Falls, Idaho

185X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Embolism, Bilateral Massive

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Thrombophlebitis, R lower Extremity

DUE TO (c) Carcinoma of Prostate

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* August 24, 1969, *to* August 25, 1969, *that I last saw the deceased alive on* August 25, 1969, *and that death occurred at* 10:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE Marion V. Kingston (Degree or title) MD 785	23b. ADDRESS Gooding Idaho	23c. DATE SIGNED 8-26-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 29, 1969	24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) Gooding,	(State) Idaho	
DATE REC'D BY LOCAL REG. Aug. 30, 1969	REGISTRAR'S SIGNATURE Eddie G. Leach	25. EMBALMER Fred J. Nelson
LICENSE NO. E-504		

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 1 1969
MAR 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3756
Local Reg. No. 3166
Reg. Dist. No. 420

RECEIVED SEP 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (In this place): 4-days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Gooding Co. Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman
d. STREET ADDRESS (If rural, give location): P.O. Box 269

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Esther	K.	Ayres	Aug. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	July 13, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Rosalia, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David F. Keith	Virginia	Olivia M. Sneed	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no -------	519-40-6337-A	[illegible]	Pacifica, Calif.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Coronary Occlusion, Recurrent	5 days.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Emphysema	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August 21, 19 69 *to* August 26, 19 69, *that I last saw the deceased alive on* 8-26-69, 19 ____, *and that death occurred at* 9.50 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Gooding, Idaho	8-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 30 1969	Hagerman Cemetery	Hagerman Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 30, 1969	[signature]	[signature]	E-511

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38.206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3757
Local Reg. No. 3167
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gooding SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
Bureau of Vital Statistics
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION D.O.G. Gooding Co. Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) Route # 2

3. NAME OF DECEASED (Type or Print) a. (First) Eusebio b. (Middle) — c. (Last) Astorquia
4. DATE OF DEATH (Month) Aug. (Day) 31, (Year) 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 29, 1894
9. AGE (In years last birthday) 74 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher-Sheepman
10b. KIND OF BUSINESS OR INDUSTRY Livestock
11. BIRTHPLACE (State or foreign country) Murelaga, Viscaya, Spain
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Adrian Astorquia BIRTHPLACE Murelaga, Viscaya, Spain
14. MOTHER'S MAIDEN NAME Teresa Gabiola BIRTHPLACE Murelaga, Viscaya, Spain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ———
16. SOCIAL SECURITY NO. 518-42-5862
17. INFORMANT'S OWN SIGNATURE X Josephine Astorquia ADDRESS Gooding Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 2days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——— , 19—, *to* Aug 31 , 1969 , *that I last saw the deceased alive on* ——— , 19—, *and that death occurred at* 11:05A m., *from the causes and on the date stated above.*

23a. SIGNATURE Douglas O Smith (Degree or title) MD
23b. ADDRESS 134 w 4th Ave Gooding
23c. DATE SIGNED 9/3/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-4-1969
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) Gooding, (State) Idaho
DATE REC'D BY LOCAL REG. Sept. 4, 1969
REGISTRAR'S SIGNATURE Eddie D. Leach
25. EMBALMER Eddie D. Leach
LICENSE NO. E-511
FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3758
Local Reg. No. 18
Reg. Dist. No. 242

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 SEP 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottenwood
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CDD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottenwood
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Wesley	F.	Orr		Aug	5	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	widowed	July 19 1880	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physican & Surgeon 14
10b. KIND OF BUSINESS OR INDUSTRY: General Practice
11. BIRTHPLACE (State or foreign country): Rochester, Minnesota
12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME: F. W. Orr — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Margaret Hamilton — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 05 1934 A
17. INFORMANT'S OWN SIGNATURE: F E Orr M D — ADDRESS: Cottenwood, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 minute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASCVD
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4-09

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~approx~~ ____, 19__, to ____, 19__, *that I last saw the deceased alive on* August 4, 1969, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William L Greenwood M.D	Grangeville, Idaho	August 11, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 9 1969	Catholic	Cottenwood, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 9, 1969	Thelma B. Nuttman RN Deputy Registrar	Clint Uhlorn	E 19

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63022

MAY 2 6 1992

Certificate of Death
STATE OF IDAHO

State File No. 3759
Local Reg. No. 31
Reg. Dist. No. 240

BIRTH NO.

RECEIVED AUG 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 25C
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 45 mi N W McCall rural-Scribner Lake area
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Scribner Lake area

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WALLACE	LEIGH	TRUMAN	August 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married	May 3, 1923	46		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Logger - Brown Tie & Lumber Company		Highmore, So. Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Rufus Truman	Villisca, Iowa	Eunice Cowin	Highmore, So. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	W W 2 4	375-30-8314	Mrs. Wallace L. Truman	McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 929X Crushing Injury of Abdomen — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
/	04	Near Scribner Lake Ida 250 Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug 11 69 9 a.m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Logging accident

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 534 IDAHO COUNTY CORONER		14 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 14, '69	McCall Cemetery	McCall Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 14 1969	Irma Cone	Burton E Walker	E-386

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 9 1969

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 1 0 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 3 0 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

State File No. 3760
Local Reg. No. 53
Reg. Dist. No. 240

RECEIVED
AUG 27 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): Kooskia Highway 12 minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 12 East of Powell

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27
b. COUNTY: Custer 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Miles City
d. STREET ADDRESS (If rural, give location): 418 South Stacy

3. NAME OF DECEASED (Type or Print)
a. (First): Arnett
b. (Middle): J.
c. (Last): Hoffman

4. DATE OF DEATH (Month) Aug. (Day) 16 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: June 13, 1912
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Hoffman — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Anna Carnes — BIRTHPLACE: Kingman, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 2/20/41-10/8/45 8199
16. SOCIAL SECURITY NO.: 517-05-5352
17. INFORMANT'S OWN SIGNATURE: Lasela L Hoffman — ADDRESS: 418 S. Stacy

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Crushing Injuries of Left Chest

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.): 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 250 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 16, 1969 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto. accident

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 553 Idaho [illegible]
23b. ADDRESS:
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Custer County Cemetery
24d. LOCATION (City, town, or county) (State): Miles City, Montana

DATE REC'D BY LOCAL REG.: Aug 23 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 27 1969

SEP 3 1969

MAR 4 1970

NOV 17 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3761
Local Reg. No. 56
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 250 SEP 1 1 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Riggins Rural Bureau of Vital
c. LENGTH OF STAY (in this place) months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Filer Ranch Salmon River 010

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elk City Rural
d. STREET ADDRESS (If rural, give location) Star Rt

3. NAME OF DECEASED (Type or Print)
a. (First) MAX
b. (Middle) CHRISTIAN
c. (Last) JESSEN

4. DATE OF DEATH (Month) (Day) (Year) August 25, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Jan 11, 1891
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner & Postmaster 08
10b. KIND OF BUSINESS OR INDUSTRY Mining & U.S. Mail
11. BIRTHPLACE (State or foreign country) Shleswig-Holestein, Germany
12. CITIZEN OF WHAT COUNTRY? 06A

13. FATHER'S NAME BIRTHPLACE
14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 03 8976
17. INFORMANT'S OWN SIGNATURE × Robert Lessenden ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Few weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) arteriosclerotic heart disease — several years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* anemia, cause undetermined polyps of stomach -

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-23-, 1969, *to* 8-4, 1969, *that I last saw the deceased alive on* 8-4, 1969, *and that death occurred at* 4.20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Donald Tillman 487 M.D.
23b. ADDRESS Grangeville, Idaho
23c. DATE SIGNED 3 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/29/69
24c. NAME OF CEMETERY OR CREMATORY Prairieview
24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Sept. 6, 1969
REGISTRAR'S SIGNATURE Irma Cone
25. EMBALMER Robert R Hansen — Robert R Hansen
LICENSE NO. E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Funeral Home

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3762
Local Reg. No. 54
Reg. Dist. No. 240

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF TOWN (If this place): 12 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General 92

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Henry
c. (Last): Marks

4. DATE OF DEATH (Month) (Day) (Year): August 27, 1969

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 18, 1917
9. AGE (In years last birthday): 51
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sawmill Worker
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Missoula, Montana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Robert Marks
BIRTHPLACE: Unk.
14. MOTHER'S MAIDEN NAME: Alice Hinesman
BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 519-18-9210
17. INFORMANT'S OWN SIGNATURE: William L. Marks
ADDRESS: Kamiah, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Lobar pneumonia
INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 26, 1969, *to* Aug 27, 1969, *that I last saw the deceased alive on* Aug 26, 1969, *and that death occurred at* 3:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 444
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 8/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 30 1969
24c. NAME OF CEMETERY [redacted]: Pine Grove
24d. LOCATION (City, town, or county): Kooskia Idaho (State): Idaho

DATE REC'D BY LOCAL REG.: Sept. 3, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert P. Hansen
LICENSE NO.: E433

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 5 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 2 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3763
Local Reg. No. 6
Reg. Dist. No. 640

RECEIVED SEP 2 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
LENGTH OF STAY (In this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 26
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): Route # 2

3. NAME OF DECEASED (Type or Print): a. (First) CYRIL JOSIAH b. (Middle) CALL c. (Last)

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 22, 1893

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chiropractor

10b. KIND OF BUSINESS OR INDUSTRY: Chiropractor

11. BIRTHPLACE (State or foreign country): Rigby, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Cyril Josiah Call Sr. BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mary Ellen Wood BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 518-46-9903

17. INFORMANT'S OWN SIGNATURE: Brent Call ADDRESS: Rte. #1 Rigby, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease 5 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4123

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 27, 1960, *to* August 9, 1969, *that I last saw the deceased alive on* August 8, 1969, *and that death occurred at* 10:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Glenn Call, M.D.

23b. ADDRESS: Rigby, Idaho

23c. DATE SIGNED: 8/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 12, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rigby Pioneer

24d. LOCATION (City, town, or county) (State): Rigby, Idaho

DATE REC'D BY LOCAL REG.: 8/12/69

REGISTRAR'S SIGNATURE: Mrs. A. B. Eckersell

25. EMBALMER: A. B. Eckersell LICENSE NO.: E-236

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 18 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3764
Local Reg. No. 6
Reg. Dist. No. 640

BIRTH NO.

RECEIVED SEP 2 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jefferson (26c)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Garfield
c. LENGTH OF STAY (In this place): 73 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rte. #1 Rigby (ore)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson (26c)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Garfield
d. STREET ADDRESS (If rural, give location): Rte. #1 Rigby

3. NAME OF DECEASED (Type or Print): a. (First) GOTTLIEB b. (Middle) CRISTIAN c. (Last) GNEITING

4. DATE OF DEATH (Month) (Day) (Year): Aug. 14, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 9, 1878

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Wertenberg, Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Adam Gneiting
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Caroline Gneiting
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-14-9203

17. INFORMANT'S OWN SIGNATURE: Afton D. Meikin
ADDRESS: Monteview, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* XXXX

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3765
Local Reg. No. 7
Reg. Dist. No. 640

Certificate of Death

RECEIVED SEP 2 1969 STATE OF IDAHO

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ririe (rural)
c. LENGTH OF STAY IN THIS (city) (county): 2 1/2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 mi. N.E. of Ririe 012

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ririe (rural)
d. STREET ADDRESS (If rural, give location): Rte. #2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LENOX	GEORGE	CROMWELL	Aug. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	Oct. 13, 1966	2 1/2				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child 02	Child	Rexburg, Idaho.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Burl Cromwell	Ida. Idaho Falls,	Barbara Newman	Utah. Salt Lake City,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	None	Burl Cromwell	Rte. 2 Rigby, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) accidental drowning — INTERVAL BETWEEN ONSET AND DEATH: X

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Home 68	Ririe 260	Jefferson	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug. 24, 1969 9:30 A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell into excavation filled with water.

22. *I hereby certify that I attended the deceased from* XXXX

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3766
Local Reg. No. 1233
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
AUG 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (rural) 83338
d. STREET ADDRESS (If rural, give location): Rt. 4

3. NAME OF DECEASED (Type or Print)
a. (First): ELIZABETH
b. (Middle): ANNE
c. (Last): BRADY

4. DATE OF DEATH (Month) (Day) (Year): Aug. 2, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 21, 1877
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Lake Prarie, Minnesota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Smith — BIRTHPLACE: Ireland
14. MOTHER'S MAIDEN NAME: Katherine Plant — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 60 8831
17. INFORMANT'S OWN SIGNATURE: X Marie M. Trappen — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): [redacted] embolism — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Mural thrombus Heart — 1 yr.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Fracture of Rt femoral neck
2. Rt Humerus — 19 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/11, 1954, *to* Aug 2, 1969, *that I last saw the deceased alive on* 8/2, 1969, *and that death occurred at* 12:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. E. Sloat 476 M.P.
23b. ADDRESS: Jerome Ida
23c. DATE SIGNED: 8/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Aug. 6, 1969
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 0 6 2000

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

State File No. 3767
Local Reg. No. 1234
Reg. Dist. No. 440

BIRTH NO. AUG 12 1969 STATE OF IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 270 Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
c. LENGTH OF STAY (in this place) 16 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Richfield Rural 83349
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) FRED
b. (Middle) WAYNE
c. (Last) POWELL

4. DATE OF DEATH (Month) Aug. (Day) 2, (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Dec. 6, 1952
9. AGE (In years last birthday) 16 — IF UNDER 1 YEAR Months 7 Days 26 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY ----
11. BIRTHPLACE (State or foreign country) Jerome, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Powell — BIRTHPLACE Gooding, Idaho
14. MOTHER'S MAIDEN NAME Carolyn (Eunice) Johnson — BIRTHPLACE Weed, Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 519-56-5981
17. INFORMANT'S OWN SIGNATURE X James W. Powell — ADDRESS Richfield, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8122

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe contusion + edema of brain, with temporal lobe skull fracture. Almost complete denudation left half skull. May have had other skull damage.

ANTECEDENT CAUSES — DUE TO (b)

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Fracture left femur; compound fract. left tibia + fibula; multiple severe lacerations both arms + thoracic wall

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 15 1/2 hrs.

19a. DATE OF OPERATION Aug 1, 1969
19b. MAJOR FINDINGS OF OPERATION All as above, with fracture line in skull grossly visible
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Country road 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Near Richfield, Idaho (Lincoln Co) 320 Refused
21d. TIME OF INJURY (Month) Aug 1 (Day) 1969 (Year) 6:30 P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car struck motorcycle boy was riding

22. *I hereby certify that I attended the deceased from* Aug 1, 1969, *to* Aug 2, 1969, *that I last saw the deceased alive on* 5:30 AM 8/3/69, *and that death occurred at* 10:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE W. Carlyle Smail 477 (Degree or title) M.D.
23b. ADDRESS Jerome, Idaho
23c. DATE SIGNED 8/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-5-1969
24c. NAME OF CEMETERY OR CREMATORY Richfield Cemetery
24d. LOCATION (City, town, or county) (State) Richfield, Idaho

DATE REC'D BY LOCAL REG. Aug. 8, 1969
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER Francis M. Bergin
LICENSE NO. E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 12 1969 Bureau of Vital Statistics

State File No. 3768
Local Reg. No. 1236
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hazelton Rural 83335
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 40
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian Rural 83642
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) Andrew b. (Middle) Alen c. (Last) Armfield

4. DATE OF DEATH (Month) (Day) (Year) Aug. 5, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Jan. 30, 1954
9. AGE (In years last birthday) 15 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William R. Armfield BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Nettie S. McCandless BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT'S OWN SIGNATURE Mrs. Mary Ann Armfield ADDRESS Meridian

18. CAUSE OF DEATH 9259
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Electrocution

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Same

DUE TO (c) Same

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) FARM. 02
21c. (CITY, TOWN, OR TOWNSHIP) Hazelton (COUNTY) Jerome 270 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 / 5 / 67 512 P. m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? NOT known

22. *I hereby certify that I attended the deceased from ——, 19—, to ——, 19—, that I last saw the deceased alive on ——, 19—, and that death occurred at —— m., from the causes and on the date stated above.*

23a. SIGNATURE Irving Altman 588 5 (Degree or title) Justice of Peace
23b. ADDRESS Jerome County, Idaho
23c. DATE SIGNED 8/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-9-69
24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery
24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 5, 1969
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER Glen G. Siren
LICENSE NO. E-498

FIRM NAME Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 12 1969 Bureau of Vital Statistics

State File No. 3769
Local Reg. No. 1235
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Jerome 270	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hazelton Rural 83335 — c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian Rural 83642
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000	d. STREET ADDRESS (If rural, give location) Rt. 2

3. NAME OF DECEASED (Type or Print)	a. (First) Roy	b. (Middle)	c. (Last) Harris	4. DATE OF DEATH (Month) (Day) (Year) Aug. 5, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 17, 1905	9. AGE (In years last birthday) 63 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hay Dealer 04	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richvale, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Benjamin B. Harris	BIRTHPLACE Illinois		14. MOTHER'S MAIDEN NAME Elizabeth Wheat	BIRTHPLACE Missouri
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 488-24-3735		17. INFORMANT'S OWN SIGNATURE Judy Hanson	ADDRESS Meridian

9259

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Electrocution

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) same

DUE TO (c) same

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Farm 04	21c. (CITY, TOWN, OR TOWNSHIP) Hazelton	(COUNTY) Jerome 270 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8/5/69 5:12 P.m.	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? Not Known	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Irving Altman 588 5 (Degree or title) Justice Office	23b. ADDRESS Jerome Country, Idaho	23c. DATE SIGNED 8/9/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE 8-9-69	24c. NAME OF CEMETERY OR CREMATORY Buckhart Cemetery	24d. LOCATION (City, town, or county) (State) Buckhart, Missouri
DATE REC'D BY LOCAL REG. Aug. 5, 1969	REGISTRAR'S SIGNATURE Louella M. Daherer	25. EMBALMER Glen G. Siren	LICENSE NO. E-498

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 4 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3770
Local Reg. No. 1237
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Nursing Home 357

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Jerome 83338
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print)
a. (First): NEIL
b. (Middle): H
c. (Last): BLACK

4. DATE OF DEATH (Month) (Day) (Year): August 8, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 24, 1902
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 64
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Ragan, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James H. Black — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: X Mabel Bisbee — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 524-34-8181
17. INFORMANT'S OWN SIGNATURE: X Edith A. Black — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

485X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chordoma, cervical & brain stem area 1 year

19a. DATE OF OPERATION: Jan. 28, 69
19b. MAJOR FINDINGS OF OPERATION: Chordoma in cervical & brain stem area c̄ cord compression
20. AUTOPSY? YES ☐ NO XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 1, 1968, *to* August 8, 1969, *that I last saw the deceased alive on* August 8, 1969, *and that death occurred at* 1:20 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Jon D. Wilmoth, M.D. 770
23b. ADDRESS: 216 East Main; Jerome, Idaho
23c. DATE SIGNED: August 11, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rosebud Cemetery
24d. LOCATION (City, town, or county) (State): Glenwood Springs, Colorado

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: Glen G. Siren
LICENSE NO.: E-498

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 21 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 11 2006

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
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STATEMENT OF PLACE OF DEATH

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ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3771
Local Reg. No. 1238
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome — AUG 27 1969
b. CITY OR TOWN: Jerome — Bureau of Vital Statistics — LENGTH OF STAY (in this place):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 304 2nd Ave. East

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NELS	MANNUEL	OLSON	August 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	March 10, 1885	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Agriculture	Elsmore, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Axel Olson	Unknown	Martha Jensen	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-22-2331	X Mrs. Grace Olson	Jerome, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probably coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Angina pectoris — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Anemia, senility, starvation —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0	—	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
0	—	—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
0 m.		—

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* Aug 1969, 19__, *that I last saw the deceased alive on* 8/7/69, 19__, *and that death occurred at* 5:35 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. Carlyse Burial	MD	Jerome Idaho	8/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	LICENSE NO.
Burial	August 12, 1969	Jerome Cemetery	Jerome Idaho	E-498

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER
Aug 21 1969	Louella M. Deherer	Glen L. Siren

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAY 7 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3772
Local Reg. No. 1239
Reg. Dist. No. 440

Certificate of Death

RECEIVED
AUG 27 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) 83338
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Utah 45
b. COUNTY Weber 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ogden, 84400
d. STREET ADDRESS (If rural, give location) 556 23rd. St.

3. NAME OF DECEASED (Type or Print)
a. (First) Gladys
b. (Middle) Edna
c. (Last) Schott

4. DATE OF DEATH (Month) (Day) (Year) Aug. 21, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Sept. 25, 1890
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Sec. 19
10b. KIND OF BUSINESS OR INDUSTRY Medical
11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME F. G. Heminger — BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Myra O'Briem — BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. -
17. INFORMANT'S OWN SIGNATURE X Elmer H Myers — ADDRESS Ogden, Utah

8199

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral concussion — INTERVAL BETWEEN ONSET AND DEATH: 4½ hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b) Trauma — "

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death* Multiple ribs fx c̄ pulm (Rt) contusion & hemorrhage — 4½ hrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Auto accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) I-80 & 93 Interchange
21c. (CITY, TOWN, OR TOWNSHIP) Jerome 270 — (COUNTY) Jerome — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 21, 1969 9:30AM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto accident - one car

22. *I hereby certify that I attended the deceased from* Aug 21, 1969, *to* Aug 21, 1969, *that I last saw the deceased alive on* Aug 21, 1969, *and that death occurred at* 1:57P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Jon D. Wilmoth, M.D. 170
23b. ADDRESS 216 E. Main; Jerome, Idaho
23c. DATE SIGNED Aug 25, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE Aug. 23, 1969
24c. NAME OF CEMETERY OR CREMATORY Aultorest Crematory
24d. LOCATION (City, town, or county) Ogden, Utah (State)

DATE REC'D BY LOCAL REG. Aug. 25 1969
REGISTRAR'S SIGNATURE Louella M. Deberer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 30 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

State File No. 3773
Local Reg. No. 1242
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton 83335
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	Harmon	Hohnhorst	August 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	March 16, 1880	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher	Stock and Farm	Mt. Zion, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNK	UNK	UNK	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		518-44-2006	Frank Hohnhorst	Hazelton, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

485X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary emphysema + abscess, Diabetes Mellitus — several years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from October 9, 1968, to August 27, 1969, that I last saw the deceased alive on August 27, 1969, and that death occurred at 3.25p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jon D. Wilmoth, M.D.	216 East Main; Jerome, Idaho	Aug. 29, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 30, 1969	Twin Falls Cemetery	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 8, 1969	Lowell M. Nelson	Ronald J. Hamilton	E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3774
Local Reg. No. 1241 (1241)
Reg. Dist. No. 440

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 8 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)
c. LENGTH OF STAY (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Barrymore District Railroad Crossing-County Rd. 270

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)
d. STREET ADDRESS (If rural, give location) Rt. 3

3. NAME OF DECEASED (Type or Print)
a. (First) Scott
b. (Middle) Alan
c. (Last) Bell

4. DATE OF DEATH (Month) (Day) (Year) Aug. 28, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH March 14, 1954
9. AGE (In years last birthday) 15 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Jerome, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harvey Jack Bell — BIRTHPLACE Jerome, Idaho
14. MOTHER'S MAIDEN NAME Maxine Toolson — BIRTHPLACE Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 60 8320
17. INFORMANT'S OWN SIGNATURE X Harvey Jack Bell — ADDRESS Rt. 3 Jerome

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8102

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) massive head injury — INTERVAL BETWEEN ONSET AND DEATH: none

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Hit by train
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Barrymore crossing
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 270 Jerome (STATE) Idaho 8333
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 28 69 40 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Rode cycle in front of trainer

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 4:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 5830 H. M. Huber, M.D. Coroner
23b. ADDRESS Jerome
23c. DATE SIGNED 29 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 30, 1969
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) Jerome, Idaho (State) 83338

DATE REC'D BY LOCAL REG. 09-04-69
REGISTRAR'S SIGNATURE M. Gene Overfield Acting Reg.
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3775
Local Reg. No. 1220
Reg. Dist. No. 440

BIRTH NO.

RECEIVED SEP 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 2 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benecict Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone 83352
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
RUTH	C.	GOLDSBROUGH	Aug.	28,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	June 18, 1892	77	2	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Fruita, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank A. Collins	Kansas	Fannie	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	A-69-1046	X Ruth C. Goldsbrough	San Raphael Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	acute Myeloid Leukemia	1 month
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Polycythemia Vera	7 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19 61, *to* Aug 28, 19 69, *that I last saw the deceased alive on* Aug 28, 19 69, *and that death occurred at* 3:20 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD 386	Box 1 Shoshone Idaho	8-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-2-1969	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 2, 1969	Louella M. Scherer	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 9 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3776
Local Reg. No. 227
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 12 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Kootenai b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene c. LENGTH OF STAY (In this place): 28 Days d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d Alene d. STREET ADDRESS (If rural, give location): 601 Front street

3. NAME OF DECEASED (Type or Print)	a. (First) EMMA	b. (Middle) T.	c. (Last) KOBS	4. DATE OF DEATH (Month) (Day) (Year)	August 1, 1969	
5. SEX: Female	6. COLOR OR RACE: Cau.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: 10/10/05	9. AGE (In years last birthday): 63	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: Fritz Perrenoud	BIRTHPLACE: UNKNOWN	14. MOTHER'S MAIDEN NAME: Carrie Olson	BIRTHPLACE: UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Mrs. Karrine Karft	ADDRESS: Hayden Lake Ida			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	12 hours.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Carcinoma - metastatic Generally	1 year.
DUE TO (c)	Carcinoma right breast	1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

1747

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* June, 1969, *to* August 1, 1969, *that I last saw the deceased alive on* August 1, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: C E Thompson	(Degree or title): M.D.	23b. ADDRESS: 920 Ironwood Dr Coeur d Alene, Idaho	23c. DATE SIGNED: 8-6-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8/4/69	24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery	24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG.: Aug. 6, 1969	REGISTRAR'S SIGNATURE: Karrine K. Brush	25. EMBALMER: Fred Noland	LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 1 2 1969
MAY 1 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3777
Local Reg. No. 225
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 1 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 603 Locust

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alvira	R.	Jeanneret	August 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 16, 1876	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward J. Rabideau	Wisconsin	Jeanett (Unobtainable)	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	None	519-03-4064	X Alvira M. Rosenbaum	Ida Coeur d'Alene

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Residues of CVA

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1967, 19__, *to* 8-4-69, 19__, *that I last saw the deceased alive on* 8-4, 1969, *and that death occurred at* 4A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W Douglas MD	Coeur d'Alene, Idaho	8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-5-1969	St Thomas Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 6, 1969	Lorraine K. Brush	Bill Leuff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 12 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3778
Local Reg. No. 223
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 12 1969 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN: Coeur d'Alene
c. LENGTH OF STAY (in this place): 2 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: New York
b. COUNTY: Yates
c. CITY OR TOWN: Dresden
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Milton	W.	Elmendorf	Aug. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	Dec. 31, 1890	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Standards Engineer	Instrument Co.	New York	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Milton M. Elmendorf	New York	Kittie Wrigley	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
W.W. I	Army	104-09-0474A	X Jeanette E. Leigh	Ida. Coeur d'Alen

4369

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Residues of CVA.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1967, 19__, *to* 8-4, 1969, *that I last saw the deceased alive on* 8-4, 1969, *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	M.D.	Coeur D'Alene Idaho	8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	8-5-69	Penfield-Oakwood Cem	Penfield New York

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 6 1969	Lorraine K. Brush	Bill Neff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 6 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3779
Local Reg. No. 223
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Worley
c. LENGTH OF STAY (in this place): 24 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): P. O. Box 74 580

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Worley
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Dorothy
b. (Middle): Marie
c. (Last): DAU

4. DATE OF DEATH (Month) (Day) (Year): August 5, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: October 15, 1890
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Fairfield, Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hans C. Hansen — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Hansena Therkildsen — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-40-6950
17. INFORMANT'S OWN SIGNATURE: x Fred Dau — ADDRESS: P. O. Box 74, Worley, Idaho

4121

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Arteriosclerotic heart disease — 15 years
DUE TO (c) Acute hypertension & cardiac decompensation — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute obesity — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 23, 1962, *to* August 5, 1969, *that I last saw the deceased alive on* Nov. 11, 1968, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 929 [signature] MD
23b. ADDRESS: Rosalia, Wa. 99170
23c. DATE SIGNED: 8-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rosewood Cemetery
24d. LOCATION (City, town, or county) (State): Fairfield, Washington

DATE REC'D BY LOCAL REG.: Aug 11 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. FUNERAL DIRECTOR: Milton L. Schanzenbach — ADDRESS: Fairfield, Wa.

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Milton S. Schangerbock Lic. No. RL 689 Fairfield, Wa. on August 3, 1969

ADDITIONAL REMARKS by Physician

Certificate of Death
STATE OF IDAHO

State File No. 3780
Local Reg. No. 232
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene c. LENGTH OF STAY (In this place) 1 Month	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Nursing Home 340	d. STREET ADDRESS (If rural, give location) 811 Government Way

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Manville	c. (Last) King	4. DATE OF DEATH (Month) (Day) (Year) August 5, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 20, 1882	9. AGE (In years last birthday) 87 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Mill 17	10b. KIND OF BUSINESS OR INDUSTRY P.F.I. Mill	11. BIRTHPLACE (State or foreign country) Minnesota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Moses King	BIRTHPLACE Indiana	14. MOTHER'S MAIDEN NAME Harriett Randall	BIRTHPLACE Indiana	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 518-01-0856	17. INFORMANT'S OWN SIGNATURE (BE) James M King	ADDRESS Coeur d'Alene, Ida	

4270

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture left femur — 2 mo
Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 5, 1962, *to* Aug. 5, 1969, *that I last saw the deceased alive on* Aug 5, 1969, *and that death occurred at* 6:05 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE Rex Henson, M.D. 225 (Degree or title)	23b. ADDRESS Coeur d'Alene, Idaho	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-7-1969	24c. NAME OF CEMETERY OR CREMATORY Forest cemetery	24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho
DATE REC'D BY LOCAL REG. Aug. 15, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. K. Tiplinger Jr.	LICENSE NO. E-397

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3781
Local Reg. No. 235
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
AUG 19 1969
Bureau of Vital Statistics

1. PLACE OF DEATH	**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission.)
a. COUNTY: Kootenai 28	a. STATE: Idaho b. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) / c. LENGTH OF STAY (In this place): Coeur d'Alene	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION: DOA Kootenai Memorial Hospital	d. STREET ADDRESS (If rural, give location): Thorpe Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elna	Rae	Wade	Aug. 6 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	not known	April 24, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	not known	Unobtainable

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable		Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (RF)	ADDRESS
------	------	518-60-4930	Mrs. Frank Thorp, Coeur d'Alene,	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Vascular Accident	1 hour
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral Arteriosclerosis	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August 6, 1969, *to* August 6, 1969, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* —m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD.	920 Ironwood Dr. Coeur d'Alene, Idaho	8-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 11, 1969	Restlawn Memorial Park	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 14, 1969	Lorraine K. Brush	Bill Duff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 19 1969

State File No. 3782
Local Reg. No. 229
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 10/

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai 28/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 1106 Fifth Street

3. NAME OF DECEASED (Type or Print) a. (First) ALMA b. (Middle) O. c. (Last) BICKERSTAFF
4. DATE OF DEATH (Month) (Day) (Year) Aug. 8, 1969

5. SEX Female
6. COLOR OR RACE Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 3/31/1885
9. AGE (In years last birthday) 84
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gustav Olson BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Anna Henderickson BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-44-0549A
17. INFORMANT'S OWN SIGNATURE Mildred Eborall ADDRESS Coeur d' Alene Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4123 ASHD. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1961, to present, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) DDS
23b. ADDRESS 920 Ironwood Dr. Coeur d'Alene Ida.
23c. DATE SIGNED 8-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/11/69
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur D' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 13, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred Noland
LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3783
Local Reg. No. 233
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
AUG 19 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 081
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 264 Northwest Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Washington 48 b. COUNTY: Kittitas 535
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ronald
d. STREET ADDRESS (If rural, give location): P. O. Box 7

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	William	Krantz	Aug.	8,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct. 30, 1922	46		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Custodian 06	C.W.S.College	Ronald, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Krantz	Austria	Helen Youk	Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (RD)	ADDRESS
no	none	536-16-4073	Mrs George W. Krantz	Ronald, Wn

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4/09

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did not , 19____, to _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. Coroner 583 4	Coeur d'alene Idaho	8-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Aug. 8, 1969	Roslyn Cemetery	Roslyn, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 14, 1969	Lorraine K Brush	Bill Huff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 2 6 1969
AUG 2 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3784
Local Reg. No. 224
Reg. Dist. No. 12

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28/ — AUG 19 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace Nur. Home 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 250
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): 109 22nd. Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DOLPHUS	J.	LA GOY	Aug. 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Married	9/9/18	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder 21	Iron welding	Ney York	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dolphus La Goy	Canada	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	113-05-2663	Ruth La Goy	109 22nd. St. Post Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1621 Bronchogenic Carcinoma c wide spread metastes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19_____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
912 Marvin Powell M.D.		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/11/69	Restlawn Memorial Park	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 13, 1969	Lorraine K. Brush	Fred Noland	E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

SEP 1 0 1969
OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3785
Local Reg. No. 230
Reg. Dist. No. 120

BIRTH NO. AUG 19 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place) 1 1/2 mo.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Nursing Home 340	d. STREET ADDRESS (If rural, give location) P. O. Box 106

3. NAME OF DECEASED (Type or Print)	a. (First) Vera	b. (Middle) M.	c. (Last) Breithaupt	4. DATE OF DEATH (Month) (Day) (Year) August 9, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 4, 1922	9. AGE (In years last birthday) 47 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ira M. Pierce	BIRTHPLACE Iowa	14. MOTHER'S MAIDEN NAME Mannie Funk	BIRTHPLACE Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 519-62-3998	17. INFORMANT'S OWN SIGNATURE ✓ Gordon J. Breithaupt	ADDRESS Idaho Coeur d'Alene	

174X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Metastatic Malignancy

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Breast

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-4, 1963, *to* 8-9, 1969, *that I last saw the deceased alive on* 8-9, 1969, *and that death occurred at* 11 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 057 C. J. Cederblom, M.D. (Degree or title)	23b. ADDRESS Hayden Lake, Idaho	23c. DATE SIGNED Aug.14,1969
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-13-1969	24c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Pk.
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho		
DATE REC'D BY LOCAL REG. Aug. 15, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. B. Ripinger Jr.
LICENSE NO. E-397		

FIRM NAME: English Chapel-Coeur d' Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 0 1969

FEB 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 2 2 1985

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 19 1969

State File No. 3786
Local Reg. No. 236
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene — c. LENGTH OF STAY (In this place) 12 Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 207 Military Drive 070	d. STREET ADDRESS (If rural, give location) 207 Military Drive

3. NAME OF DECEASED (Type or Print) a. (First) SIDNEY	b. (Middle) H.	c. (Last) WOODCOCK	4. DATE OF DEATH (Month) (Day) (Year) Aug. 11, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7/3/1890	9. AGE (In years last birthday) 79 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist 22	10b. KIND OF BUSINESS OR INDUSTRY Owened Drug Store	11. BIRTHPLACE (State or foreign country) Wisconsin	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Woodcock	BIRTHPLACE Wisconsin	14. MOTHER'S MAIDEN NAME Nellie Richardson	BIRTHPLACE U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-36-2934	17. INFORMANT'S OWN SIGNATURE Ella Woodcock	ADDRESS 207 Military Drive Coeur d' Alene, Ida.	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 20 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Donald M Gumprecht (Degree or title) 142	23b. ADDRESS 302 W 5th	23c. DATE SIGNED 14 Aug	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/14/69	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG. Aug. 14, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Fred Noland	LICENSE NO. E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 7 1969

SEP 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 3 0 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

SEP 3 0 1969

OCT 1 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

DEC 2 4 1969

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

JAN 1 9 1970

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
AUG 19 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3787
Local Reg. No. 231
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH 281
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeu r d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home 1817 Nora 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 1817 Nora

3. NAME OF DECEASED (Type or Print)
a. (First) Lloyd
b. (Middle) P.
c. (Last) Covill

4. DATE OF DEATH (Month) (Day) (Year) August 12, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 22, 1899
9. AGE (In years last birthday) 69
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector 20
10b. KIND OF BUSINESS OR INDUSTRY Kaiser Aluminum
11. BIRTHPLACE (State or foreign country) Wisc.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Covill
BIRTHPLACE (Unobtainable)
14. MOTHER'S MAIDEN NAME Mary
BIRTHPLACE (Unobtainable)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-03-0449
17. INFORMANT'S OWN SIGNATURE Mrs. Jessie Covill
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial infarct — 3 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1969, *to* 8-11, 1969, *that I last saw the deceased alive on* 8/16, 1969, *and that death occurred at* 8:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Hesse Barclay MD (Degree or title)
23b. ADDRESS Coeur d' Alene, Ida
23c. DATE SIGNED 8-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug.15,1969
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. Aug.15,1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. R. Riplinger Jr.
LICENSE NO. E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 0 1969
AUG 2 8 1969
JUN 1 4 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3788
Local Reg. No. 238
Reg. Dist. No. 120

RECEIVED AUG 28 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY IN (this place) 3½ Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls Route #2
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) JOHN c. (Last) GOLOB

4. DATE OF DEATH (Month) Aug. (Day) 14, (Year) 1969

5. SEX Male

6. COLOR OR RACE Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 5/12/05

9. AGE (In years last birthday) 64
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electricion 21

10b. KIND OF BUSINESS OR INDUSTRY Kaiser Plant

11. BIRTHPLACE (State or foreign country) Penn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Vincent Golob
BIRTHPLACE Austria

14. MOTHER'S MAIDEN NAME Elizabeth Kromwinkle
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW I 3

16. SOCIAL SECURITY NO. 518-01-6849

17. INFORMANT'S OWN SIGNATURE Route # 2
ADDRESS Zora Golob Post Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1539

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of the bowel — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. W. deepened metastasis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19 56 to _____, 19 69, that I last saw the deceased alive on Aug 13, 1969, and that death occurred at 6a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS 302 w 5th

23c. DATE SIGNED 15 Aug.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/16/69

24c. NAME OF CEMETERY OR CREMATORY Evergreen cemetery

24d. LOCATION (City, town, or county) (State) Post Falls, Idaho

DATE REC'D BY LOCAL REG. Aug 18 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

69-8282
BIRTH NO.

RECEIVED
AUG 28 1969
Bureau of Vital Statistics

State File No. 3789
Local Reg. No. 237
Reg. Dist. No. 120

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 310 4th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Paul	Ryan	Bruss	Aug. 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	never married	Aug. 4, 1969		12	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Coeur d'Alene, Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arnold Bruss	Minnesota	Lonnie Fausett	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (BE)	ADDRESS
----- V	------	none	Mrs. A. R. Bruss	Coeur d'Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Fulminating pneumonia — 486X — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 4, 1969, *to* Aug 16, 1969, *that I last saw the deceased alive on* Aug 16, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. H. English MD	Hayden Lake, Idaho	8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 19, 1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 21, 1969	Lorraine K. Brush	Donald C. English	E337

FIRM NAME: English Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 9 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3790
Local Reg. No. 241
Reg. Dist. No. 120

RECEIVED
AUG 28 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lower Twin Lakes
LENGTH OF STAY (in this place): 24 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION: West Side Lower Twin Lakes 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Spokane 55
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): E. 1227 Wabash Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ellis	S.	Wright	August	16	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	2/24/98	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carman 70	Great Northern RR	Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jack Wright	Unknown	Elsie Rowe	Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	701-10-9922	E. Wayne Wright	3614 W Tryon Spok. Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Probable acute Coronary occlusion	Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:00 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 583 4 (Degree or title) Coroner	Coeur d'alene Idaho	8-18-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	8/19/69	Greenwood Memorial Terrace	Spokane	Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 21, 1969	Lorraine K. Brush	E. H. Rothwell	OL 998

FIRM NAME: Hazen & Jaeger Funeral Homes, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 0 6 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
AUG 28 1969
Bureau of Vital Statistics

State File No. 3791
Local Reg. No. 240
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
b. STAY (In this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memerial Hospital 10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls-Rural Rt. #1
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)
a. (First): DELBERT JACK
b. (Middle):
c. (Last): RICE

4. DATE OF DEATH (Month) (Day) (Year): August 17, 1969

5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 24, 1888
9. AGE (In years last birthday): 80
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rail Road 10
10b. KIND OF BUSINESS OR INDUSTRY: S.andI. R.R.
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
BIRTHPLACE: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN
BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 539-05-6562A
17. INFORMANT'S OWN SIGNATURE: Ida Rice Post Falls, Idaho
ADDRESS: Route #1

428X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Fracture of left Femur — 4 days
Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 6, 1962, *to* Aug 17, 1969, *that I last saw the deceased alive on* Aug 17, 1969, *and that death occurred at* 6 P. *m., from the cause and on the date stated above.*

23a. SIGNATURE: Rex T. Henson, M.D. 225 (Degree or title)
23b. ADDRESS: Coeur d'Alene Idaho
23c. DATE SIGNED: Aug 22, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/21/69
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Park
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Aug. 25, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred Noland
LICENSE NO.: E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 1969

MAR 2 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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A Barclay

Certificate of Death
STATE OF IDAHO

RECEIVED
AUG 28 1969
Bureau of Vital Statistics

State File No. 3792
Local Reg. No. 239
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY KOOTENAI 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY KOOTENAI 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) COEUR D' ALENE; STAY (In this place) TWO DAYS	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) COEUR D' ALENE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) KOOTENAI MEMORIAL HOSPITAL 101	d. STREET ADDRESS (If rural, give location) 915-C-STREET

3. NAME OF DECEASED (Type or Print)	a. (First) BERNADINE	b. (Middle) GENEVA	c. (Last) PAYNE	4. DATE OF DEATH (Month) (Day) (Year) AUGUST 20, 1969
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 5, 1907	9. AGE (In years last birthday) 62 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 01	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) LANE, IDAHO	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IVER E. MOE	BIRTHPLACE WISCONSIN	14. MOTHER'S MAIDEN NAME NELLIE M. WHISNER	BIRTHPLACE MISSOURI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE	16. SOCIAL SECURITY NO. 518-26-6679	17. INFORMANT'S OWN SIGNATURE W. Floyd Payne	ADDRESS Cda, Idaho	

18. CAUSE OF DEATH 5310
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial failure	few min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	severe hemorrhage from	
DUE TO (c)	gastric ulcer.	2 da.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 8-19-69
19b. MAJOR FINDINGS OF OPERATION bleeding gastric ulcer.
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 8-18, 1969, *to* 8-20, 1969, *that I last saw the deceased alive on* 8-20, 1969, *and that death occurred at* 945A *m., from the causes and on the date stated above.*

23a. SIGNATURE Bernard Barclay 25	(Degree or title) MD	23b. ADDRESS Coeur d'Alene Ida	23c. DATE SIGNED 8-25-69
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL-BURIAL 3	24b. DATE 8-23-69	24c. NAME OF CEMETERY OR CREMATORY PINES CEMETERY	24d. LOCATION (City, town, or county) (State) OPPORTUNITY, WASHINGTON
DATE REC'D BY LOCAL REG. Aug. 26, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Ziplinger Jr.	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: ENGLISH CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 8 1969
SEP 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3793
Local Reg. No. 243
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give ...) 907 Second Street

3. NAME OF DECEASED (Type or Print) a. (First) SELMA b. (Middle) J. c. (Last) DAVIDSON

4. DATE OF DEATH (Month) Aug. (Day) 21, (Year) 1969

5. SEX Female
6. COLOR OR RACE Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 10/3/04
9. AGE (In years last birthday) 64
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN Nordstrand BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Hannah Norberg BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Robert Davidson ADDRESS Seattle, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

0361

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Waterhouse-Friderichsen Syndrome

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) E Coli Septicemia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus Generalized A.S.H.D.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 65 *to* present *, that I last saw the deceased alive on* 8-21-69 *, and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS 920 Ironwood Dr. Coeur d'Alene, Idaho
23c. DATE SIGNED 8-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/25/69
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Aug 27, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Frank Houde
LICENSE NO. E-521

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3794
Local Reg. No. 251
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alen
c. LENGTH OF STAY (In this place) 2 Mon.
d. FULL NAME OF HOSPITAL OR INSTITUTION Sunset Terrace Nur. Home 346

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 252
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) Box 547 Post Falls, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LOUISA	S.	RADA	Aug. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Cau.	Widowed	5/4/1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Minn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	516-16-2681D	June Shumway	Post Falls, Idaho

4124

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A. S. C. V. D. — 10 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Depression

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
24 Jun 69	Cholecystectomy, Cholelithiasis	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 23 July, 1969, to 21 Aug, 1969, that I last saw the deceased alive on 21 Aug, 1969, and that death occurred at 4 P.M. from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert S. West	MD	920 Ironwood Drive, CdA, Ida	26 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8/22/69	Clayton Funeral Home	Wolf Point, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 27, 1969	Lorraine K. Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3795
Local Reg. No. 245
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur D' Alene c. LENGTH OF STAY (In this place) Mon.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeurd' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Terrace Nur. Home 340	d. STREET ADDRESS (If rural, give location) Sunset Terrace Nur. Home

3. NAME OF DECEASED (Type or Print) a. (First) LEONA	b. (Middle)	c. (Last) DEVICH	4. DATE OF DEATH (Month) (Day) (Year) Aug. 22, 1969	
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9/5/1896	9. AGE (In years Birthday) 72 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender 33	10b. KIND OF BUSINESS OR INDUSTRY Own Bar	11. BIRTHPLACE (State or foreign country) Wisconsin	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN	BIRTHPLACE UNKNOWN	14. MOTHER'S MAIDEN NAME UNKNOWN	BIRTHPLACE UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 534-22-3700A	17. INFORMANT'S OWN SIGNATURE Gompf Funeral Home	ADDRESS Libby, Montana	

1621

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic carcinoma

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of the lung

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-26, 19 68, *to* 8-22, 19 69, *that I last saw the deceased alive on* 8-3-68, 19 ___, *and that death occurred at* 5:30a.m. *from the causes and on the date stated above.*

23a. SIGNATURE 087 C. J. Cederblom, M.D. (Degree or title)	23b. ADDRESS Hayden Lake, Idaho	23c. DATE SIGNED 8-28-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE 8/23/69	24c. NAME OF CEMETERY OR CREMATORY Gompf Funeral Home	24d. LOCATION (City, town, or county) (State) Libby Montana
DATE REC'D BY LOCAL REG. Aug. 29, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Fred Noland	LICENSE NO. E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 1969
AUG 14 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. A. Barclay

Certificate of Death
STATE OF IDAHO

State File No. 3796
Local Reg. No. 252
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY KOOTENAI 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY KOOTENAI 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) COEUR D' ALENE c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) COEUR D' ALENE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 412-W-LINDEN AVENUE 000	d. STREET ADDRESS (If rural, give location) 412-W-LINDEN AVENUE

3. NAME OF DECEASED (Type or Print)	a. (First) RALPH	b. (Middle) A.	c. (Last) STACKHOUSE	4. DATE OF DEATH (Month) AUGUST (Day) 23, (Year) 1969
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 11, 1886	9. AGE (In years last birthday) 82 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 04	10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	11. BIRTHPLACE (State or foreign country) HUNTLEY, NEBRASKA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orlando Stackhouse	BIRTHPLACE Ill.	14. MOTHER'S MAIDEN NAME Nellie Ellston	BIRTHPLACE Ill.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE	16. SOCIAL SECURITY NO. 518-24-0895	17. INFORMANT'S OWN SIGNATURE Mary J. Stackhouse	ADDRESS COEUR D"ALENE	

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH immed.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Emphysema — 3 yr.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* 8-23, 19 69, *that I last saw the deceased alive on* 8-22, 19 69, *and that death occurred at* 5 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Ralph Barclay 025 (Degree or title) MD	23b. ADDRESS Coeur d'Alene Ida	23c. DATE SIGNED 8-25-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-26-1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho
DATE REC'D BY LOCAL REG. Aug. 28, 1969	REGISTRAR'S SIGNATURE Lorraine K Brush	25. EMBALMER N. F. Stiplinger Jr.	LICENSE NO. E-397

FIRM NAME: ENGLISH CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 1969
JUN 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 4 1969 Bureau of Vital Statistics

State File No. 3797
Local Reg. No. 242
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene c. LENGTH OF STAY (In this place): 1 day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location): 1060 Lincoln Way

3. NAME OF DECEASED (Type or Print) a. (First): Jennie	b. (Middle): D.	c. (Last): Cogger	4. DATE OF DEATH (Month) (Day) (Year): August 24, 1969		
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Aug. 29, 1920	9. AGE (In years last birthday): 48	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Minn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Julius Pinatelli	BIRTHPLACE: Italy	14. MOTHER'S MAIDEN NAME: (Unobtainable)	BIRTHPLACE: (Unobtainable)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----- (If yes, give war or dates of service) ----------	16. SOCIAL SECURITY NO.: 473-22-2522	17. INFORMANT'S OWN SIGNATURE: x Raymond Cogger	ADDRESS:		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1830

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Abdominal Carcinomatosis	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Ovarian Cystadenocarcinoma	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 7/3/69	19b. MAJOR FINDINGS OF OPERATION: Disseminated Peritoneal Carcinomatosis	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify): N/A	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): N/A
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): N/A m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? N/A

22. *I hereby certify that I attended the deceased from* 7-10- *, 19*69*, to* 23 Aug *, 19*69*, that I last saw the deceased alive on* 23 August *, 19*69*, and that death occurred at* 3 30 *A.m., from the causes and on the date stated above.*

23a. SIGNATURE: Robert S. West 911	(Degree or title): MD	23b. ADDRESS: 920 Fran wood Drive	23c. DATE SIGNED: 26 Aug 1969
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8-27-1969	24c. NAME OF CEMETERY OR CREMATORY: St. Thomas Cemetery	24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG.: Aug. 28, 1969	REGISTRAR'S SIGNATURE: Lorraine K Brush	25. EMBALMER: N. F. Tiplinger Jr.	LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d'Alene, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 1969
SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3798
Local Reg. No. 244
Reg. Dist. No. 120

BIRTH NO.

RECEIVED SEP 4 1969

1. PLACE OF DEATH
a. COUNTY 28 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Coeur d' Alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48 b. COUNTY Spokane 333
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 315 W. Riverside Ave. (Formerly)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CLEMENT	F.	DIONNE	August 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	11-28-1898	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Mail Clerk 08	U.S.Government	Iron River, Wisconsin	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ferdinand Dionne	Not obt	Henrietta Bouffioux	Not obt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	538-42-0824	Self - prearrangements	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen. Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death
Prostatectomy 1967 with suprapubic drainage

INTERVAL BETWEEN ONSET AND DEATH: 6 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Gangrene	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 24, 1969, *to* Aug 24, 1969, *that I last saw the deceased alive on* Aug 23, 1969, *and that death occurred at* 6:57 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
146 [signature]	MD	Coeur d Alene	8/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-27-69	Riverside Memorial Park	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
Aug 29, 1969	Lorraine K. Brush	Stanley May-Smith Funeral Home-Spokane, Washington

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 25 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3799
Local Reg. No. 246
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene, Idaho
d. STREET ADDRESS (If rural, give location) 716 W. Garden Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Johan
b. (Middle) O.
c. (Last) Finnebott

4. DATE OF DEATH (Month) August (Day) 24, (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH August 9, 1885
9. AGE (In years last birthday) 84
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ole Finnebott
BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Ingeborg Nesse
BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-40-6905
17. INFORMANT'S OWN SIGNATURE Elmer Ness
ADDRESS

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral vascular accident	5 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral arteriosclerosis	years
DUE TO (c)	Generalized arteriosclerosis	years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Gouty arthritis	years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 19, 1969, *to* Aug 24, 1969, *that I last saw the deceased alive on* Aug 24, 1969, *and that death occurred at* 12:05p *m., from the causes and on the date stated above.*

23a. SIGNATURE W. Wray Wilson MD (Degree or title) 568
23b. ADDRESS Coeur d'Alene, Idaho
23c. DATE SIGNED 8/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-27-1969
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. Aug 28, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

FIRM NAME: English Chapel-Coeur d' Alene, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 1969

FEB 0 9 2000

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3800
Local Reg. No. 247
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai — SEP 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL Coeur d'Alene
c. LENGTH OF STAY in this place:

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Washington — b. COUNTY: Spokane
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): 6110 Elgin St,

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carlin Bay, Coeur d'Alene Lake

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Casey	D.	Jones	Aug. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 8, 1925	44		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carbon Setter	Kaiser Aluminum	Washington	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George L. Jones	unob.	Lilly May Davis	unob.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes War Two	533-20-8233	Mrs. Janet Bench (Wife)	Portland, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) accidental traumatism due — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) to airplane accident — Sudden
DUE TO (c) Cardiac Tamponade due to

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ruptured pulmonary artery — "

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	Lake Coeur d'alene	Carlin Bay. Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR
Aug. 24, 1969 3p. m.		Plane hit Line. Fell into Lake

22. *I hereby certify that I attended the deceased from* Did not *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE AND (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. Coroner	Coeur d'Alene Idaho	8-26-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	8-25-69	Riverside Memorial P.	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 28, 1969	Lorraine K Brush	[illegible]	E-397

FIRM NAME: Hazen Jaeger Funeral Home
Spokane, Washington

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 4 1969
SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3801
Local Reg. No. 248
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL Coeur d'Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carlin Bay, Coeur d'Alene Lake 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Washington 48
b. COUNTY: Spokane 55
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): 6110 Elgin St.

3. NAME OF DECEASED (Type or Print)
a. (First): David
b. (Middle): Leroy
c. (Last): Jones

4. DATE OF DEATH (Month) (Day) (Year): Aug. 24, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Nov. 24, 1954
9. AGE (In years last birthday): 14
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Salk Jr.H.S.
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Casey D. Jones
BIRTHPLACE: Washington
14. MOTHER'S MAIDEN NAME: Gretta Kroetch
BIRTHPLACE: Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: Mrs. Janet Bench (NR)
ADDRESS: Portland, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8414

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Accidental Traumatism due to airplane accident
INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): to airplane accident
DUE TO (c): Head injury - Probable Skull Fract
"

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Lake Coeur d'alene
21c. (CITY, TOWN, OR TOWNSHIP) 280 (COUNTY) (STATE): Carlin Bay. Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8-24-'69 3 p. m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Plane hit line and fell to Lake.

22. I hereby certify that I attended the deceased from Did not - , 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE: William T. Wood, M.D. 583 (Degree or title) Coroner
23b. ADDRESS: Coeur d'alene Idaho
23c. DATE SIGNED: 8-26-'69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal&Burial 3
24b. DATE: 8-25-69
24c. NAME OF CEMETERY OR CREMATORY: Riverside Memorial P.
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: Aug 28, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N. F. Riplinger Jr.
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hazen Jaeger Funeral Home
Spokane, Wash.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 9 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3802
Local Reg. No. 249
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Kootenai 280	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Washington 48 b. COUNTY: Spokane 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL Coeur d'Alene c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carlin Bay, Coeur d'Alene Lake 000	d. STREET ADDRESS (If rural, give location): 6110 Elgin St.

3. NAME OF DECEASED (Type or Print)	a. (First): Gretta	b. (Middle): Claire	c. (Last): Jones	4. DATE OF DEATH (Month) (Day) (Year): Aug. 24, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 4-25-29	9. AGE (In years last birthday): 40 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: own home	11. BIRTHPLACE (State or foreign country): Washington	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Joseph E. Kroetch	BIRTHPLACE: (unob.)	14. MOTHER'S MAIDEN NAME: Anita Ritch	BIRTHPLACE: (unob.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): none	16. SOCIAL SECURITY NO.: 534-26-2002	17. INFORMANT'S OWN SIGNATURE: Mrs. Janet Bench (NR)	ADDRESS: Portland, Ore.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8414

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	accidental traumatism due to	Sudden.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	airplane accident	
DUE TO (c)	Skull Fracture	"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Lake Coeur d'alene	21c. (CITY, TOWN, OR TOWNSHIP) 280 (COUNTY) (STATE): Carlin Bay Kootenai Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8-24-'69 3p. m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Plane hit line and fell into Lake.	

22. *I hereby certify that I attended the deceased from* Did not. *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood, M.D. Coroner 583 4 (Degree or title)	23b. ADDRESS: Coeur d'alene, Idaho	23c. DATE SIGNED: 8-26-'69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal&Burial 3	24b. DATE: 8-25-69	24c. NAME OF CEMETERY OR CREMATORY: Riverside Memorial P	24d. LOCATION (City, town, or county) (State): Spokane, Washington
DATE REC'D BY LOCAL REG.: Aug. 28, 1969	REGISTRAR'S SIGNATURE: Lorraine K. Brush	25. EMBALMER: M. F. Ripling Jr.	LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hazen Jaeger Funeral Home
Spokane, Washington

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 4 1969
SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3803
Local Reg. No. 250
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place): 2 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene Rural Rt. 2
d. STREET ADDRESS (If rural, give location): Route #2 Box 51

3. NAME OF DECEASED (Type or Print)
a. (First): KEVIN
b. (Middle): E.
c. (Last): MARTIN

4. DATE OF DEATH: (Month) Aug. (Day) 25, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 7/8/61

9. AGE (In years last birthday): 8
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Newport, Washington

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Darrell Martin — BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Carmelita Selvage — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Darrell Martin Route #2 Box 51 Coeurd' Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Massive Cerebral Hemorrhage and Laceration with Herniation Uncal Gyrus — INTERVAL BETWEEN ONSET AND DEATH: 15'

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Multiple Skull Fractures with Epidural Hematoma — 20'
DUE TO (c): Auto - Bicycle Accident. — 1 hr.

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: Liver Laceration - Hemoperitoneum
Fx (R) Femur

19a. DATE OF OPERATION: 25 Aug 69

19b. MAJOR FINDINGS OF OPERATION: (R) Temporal Epidural Hematoma, Subdural Hematoma

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Pickup & Bicycle

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 4th Street @ Honeysuckle

21c. (CITY, TOWN, OR TOWNSHIP): Coeur d'Alene — (COUNTY): Kootenai — (STATE): Idaho

21d. TIME OF INJURY: (Month) 8 (Day) 25 (Year) 69 (Hour) 2:50 p.m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?: Bike Ridden into path of Pickup Truck

22. *I hereby certify that I attended the deceased from* 25 Aug, 1969, to 25 Aug, 1969, *that I last saw the deceased alive on* 25 Aug, 1969, *and that death occurred at* 3:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert S West — (Degree or title): M.D. 911

23b. ADDRESS: 920 Ironwood Drive

23c. DATE SIGNED: 28 Aug. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/27/69

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Aug. 29, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brueck

25. EMBALMER: Fred Noland

LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED SEP 4 1969 Bureau of Vital Statistics

State File No. 3804
Local Reg. No. 253
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place): 2 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1124 N. 16th. Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 1124 N. 16th. Street

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE; b. (Middle); c. (Last) SUNDRUD

4. DATE OF DEATH: (Month) AUG. (Day) 26, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 10/31/13

9. AGE (In years last birthday): 55

IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Minn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Louis Sundrud — BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Margret Berg — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE / ADDRESS: Lois Sundrud 1124 N. 16th, Cd'A, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 2000 Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Reticulum cell sarcoma of bone unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-5, 1968, *to* 8-26, 1969, *that I last saw the deceased alive on* 8-25, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: R. H. Eggleston 658 (Degree or title) MD

23b. ADDRESS: Hayden Lake Idaho

23c. DATE SIGNED: 8-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 8/27/69

24c. NAME OF CEMETERY OR CREMATORY: Carlin Funeral Home

24d. LOCATION (City, town, or county) (State): Fosston Minn.

DATE REC'D BY LOCAL REG.: Aug 29, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland

LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 12 1970

MAR 6 1970

JAN 12 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 8 1969
Bureau of Vital Statistics

State File No. 3805
Local Reg. No. 254
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 19 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): 516 Spokane St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Franklin	Conrad	Engan	Aug. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 17, 1912	57		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Ohio Match Co.	North Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oliver Engan	Atwater, Minnesota	Emma Louise Paulson	Atwater, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	501-03-3611	Mrs. F. C. Engan	Post Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5710

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Laennec's Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Congestive Heart Failure — 2 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June, 1969, to August 31, 1969, that I last saw the deceased alive on August 31, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. E. Thompson	MD	Coeur d'Alene, Idaho	Sept. 3, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 3, 1969	Evergreen Cemetery	Post Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 4, 1969	Lorraine K. Brush	Bill Leuff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3806
Local Reg. No. 255
Reg. Dist. No. 120

BIRTH NO.

RECEIVED SEP 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): Route #3, Box 270

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Frank	Henry	Lafrenz	August 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 21, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired-Educator 12	Public Schools	Verdigree, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nicholas Lafrenz	Germany	Antonette Drobny	Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No / None	519-32-7503	X Esther Lafrenz	Rt 3 Coeur d'Alene, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1702 Uremia Poisoning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Generalyd Carcinomatosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1967	Malignant Tumor in Sigmoid	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1967 *to* Aug 30 1969 *that I last saw the deceased alive on* Aug 31 1969 *and that death occurred at* 1 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lloyd Bell MD 1920	Coeur d'Alene	9/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 3, 1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 4, 1969	Lorraine K. Brush	Bill Cuff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 17 1969
Bureau of Vital Statistics

State File No. 3807
Local Reg. No. 262
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location) 706 Garden Avenue

3. NAME OF DECEASED (Type or Print) a. (First) HENRY	b. (Middle) F.	c. (Last) PECOR	4. DATE OF DEATH (Month) Aug. (Day) 31, (Year) 1969		
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/26/69	9. AGE (In years last birthday) 71	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier 10	10b. KIND OF BUSINESS OR INDUSTRY Souix Line R.R.	11. BIRTHPLACE (State or foreign country) Rhinelander, Wis.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nazair Pecor	BIRTHPLACE Canada	14. MOTHER'S MAIDEN NAME UNKNOWN	BIRTHPLACE UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 701-10-4238	17. INFORMANT'S OWN SIGNATURE Bernice Pecor	ADDRESS 706 Garden Ave. Coeur d' Alene, Ida.		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma lung — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Possible Carcinoma Pancreas -

19a. DATE OF OPERATION March 69	19b. MAJOR FINDINGS OF OPERATION Carcinoma lung	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1969, *to* Aug 31, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Donald M Gumprecht MD (Degree or title)	23b. ADDRESS 302 ~ 5th	23c. DATE SIGNED 4 Sept 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE 9/3/69	24c. NAME OF CEMETERY OR CREMATORY Hilderbrand Funeral	24d. LOCATION (City, town, or county) (State) Home-Rhinelander, Wisconsin
DATE REC'D BY LOCAL REG. Sept. 10 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Fred Noland	LICENSE NO. E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3808
Local Reg. No. 92
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Route 1 Moscow
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Olaf b. (Middle) Hjalmer c. (Last) Olson

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Feb. 21, 1905

9. AGE (In years last birthday) 64
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Park, Idaho

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Andrew H. Olson
BIRTHPLACE Sweden

14. MOTHER'S MAIDEN NAME Hannah Olson
BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-12-4402

17. INFORMANT'S OWN SIGNATURE X Helen M. Olson
ADDRESS Moscow, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach & Metastases
INTERVAL BETWEEN ONSET AND DEATH 10 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY occur?

22. I hereby certify that I attended the deceased from June, 1966, to July 15, 1969, that I last saw the deceased alive on July 2, 1969, and that death occurred at 4:40 m., from the causes and on the date stated above.

23a. SIGNATURE Clyde A. West (Degree or title) M.D.

23b. ADDRESS Pullman Washington

23c. DATE SIGNED 7-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 18, 1969

24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery

24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 3 Sept 1969

REGISTRAR'S SIGNATURE Wayne R Heikkari

25. EMBALMER E. Pete Albertson

LICENSE NO. E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3809
Local Reg. No. 84
Reg. Dist. No. 200

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Latah 291

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow

c. LENGTH OF STAY (in this place): 7 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Latah 291

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow

d. STREET ADDRESS (If rural, give location): 509 E. 6th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Hastings	Blane	August	1	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	married	May 9, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Mayfield, Ky.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter W. Blane	Tenn.	Marybell Lewis	Ky.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-34-7061	Mrs James H Blane	Moscow, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severe Coronary artery Disease — yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Cerebral Vascular accident — 4 yrs. + 2 wks.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 25, 1969, *to* Aug 1, 1969, *that I last saw the deceased alive on* Aug 1, 1969, *and that death occurred at* 4:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R D Brooks OSB MD.	Moscow Idaho	Aug. 18, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 5, 1969	Palouse Cemetery	Palouse Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
21 August 1969	Maynard Heiskari	E. Pete Albertson	E-525

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 3 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 7 1987

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3810
Local Reg. No. 80
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 19 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print)
a. (First): Fred
b. (Middle): Perry
c. (Last): Robison

4. DATE OF DEATH (Month) (Day) (Year): August 1 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 16, 1902
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): logger 17
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred Robison — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Grace Snodgrass — BIRTHPLACE: Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-36-8762
17. INFORMANT'S OWN SIGNATURE: Mrs Vern Parrish — ADDRESS: Palouse, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): arterial sclerosis + Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ageing changes
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Moscow, Latah, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-5, 1956, *to* 8-1, 1969, *that I last saw the deceased alive on* 6-19, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lakele J. Stephens
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 8-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 11 Aug 1969
REGISTRAR'S SIGNATURE: Wayne R Hiskari
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3811
Local Reg. No. 79
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 12 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 422 No. Washington

3. NAME OF DECEASED (Type or Print)
a. (First): Hazel
b. (Middle): Lee
c. (Last): Hammond

4. DATE OF DEATH (Month) (Day) (Year): Aug 3 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Nov 8, 1890
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): LaGrande, Ore.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Abraham Warlick — BIRTHPLACE: N.C.
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-32-6717D
17. INFORMANT'S OWN SIGNATURE: X Wayne Hammond — ADDRESS: Moscow

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary artery disease with Venomotive febrilation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart disease with failure
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Secondary Anemia

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-22, 1934, *to* 8-3, 1969, *that I last saw the deceased alive on* 8-3, 1969 *and that death occurred at* 2150 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph G. Wilson MD
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 8-6 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 8 August 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3812
Local Reg. No. 81
Reg. Dist. No. 200

BIRTH NO.

RECEIVED
AUG 19 1969

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman General Hospital 12

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
d. STREET ADDRESS (If rural, give location): Box - 264

3. NAME OF DECEASED (Type or Print)
a. (First): ROY
b. (Middle): HAYNES
c. (Last): EVANS

4. DATE OF DEATH: (Month) 5 (Day) August (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 8 February 1890

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 4

10b. KIND OF BUSINESS OR INDUSTRY: Stock & Grain

11. BIRTHPLACE (State or foreign country): Genesee, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Sanford Evans
BIRTHPLACE: W. Virginia

14. MOTHER'S MAIDEN NAME: Emma Burgess
BIRTHPLACE: W. Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW-I 3

16. SOCIAL SECURITY NO.: 519 42 3311

17. INFORMANT'S OWN SIGNATURE: Hilda E Evans
ADDRESS: Genesee, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemmorhage 4319
INTERVAL BETWEEN ONSET AND DEATH: 4 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1967 *to* Aug 1968, *that I last saw the deceased alive on* Aug 5, 1969, *and that death occurred at* 6:20 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward Brower MD

23b. ADDRESS: Moscow Idaho

23c. DATE SIGNED: 8-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8 August 1969

24c. NAME OF CEMETERY OR CREMATORY: Genesee City Cemetery

24d. LOCATION (City, town, or county) (State): Genesee, Latah Co., Idaho

DATE REC'D BY LOCAL REG.: 18 Aug 1969

REGISTRAR'S SIGNATURE: Dwayne R Heiskari

25. EMBALMER: W E Black

LICENSE NO.: E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 2 4 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3813
Local Reg. No. 83
Reg. Dist. No. 200

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 241
b. CITY OR TOWN: Moscow
LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 241
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 809 East "B"

3. NAME OF DECEASED (Type or Print): a. (First) Raymond b. (Middle) Hanlon c. (Last) Mc Quade

4. DATE OF DEATH: (Month) August (Day) 8 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 18, 1910

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): University of Idaho 08

10b. KIND OF BUSINESS OR INDUSTRY: Physical Plant

11. BIRTHPLACE (State or foreign country): Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph McQuade
BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Mary Ellen Farnon
BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-28-6877

17. INFORMANT'S OWN SIGNATURE: Frances McQuade
ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial fibrillation
INTERVAL BETWEEN ONSET AND DEATH: Hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) myocardial infarct
DUE TO (c) coronary atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1966, to Aug. 1969, that I last saw the deceased alive on 8-7-69, and that death occurred at 9:[illegible] m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] (Degree or title) OST
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 8/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Missoula Catholic
24d. LOCATION (City, town, or county) (State): Missoula Montana

DATE REC'D BY LOCAL REG.: 20 August 1969
REGISTRAR'S SIGNATURE: Wayne R Weisleari
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 27 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 15 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3814
Local Reg. No. 86
Reg. Dist. No. 200

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

AUG 26 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 40 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Deary
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print): a. (First) Kenneth; b. (Middle) Nathaniel; c. (Last) Churchill

4. DATE OF DEATH: (Month) August (Day) 11 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: July 20, 1900

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woodsman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washburn, Maine

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nathaniel Churchill
BIRTHPLACE: Maine

14. MOTHER'S MAIDEN NAME: Lucille Corlis
BIRTHPLACE: Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 005-24-8863

17. INFORMANT'S OWN SIGNATURE: Kenneth Nathaniel Churchill
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-28, 1968, *to* 8-11, 1969, *that I last saw the deceased alive on* 8-10, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O Drury MD
23b. ADDRESS: Troy Idaho
23c. DATE SIGNED: 8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Deary Idaho

DATE REC'D BY LOCAL REG.: 21 August 1969
REGISTRAR'S SIGNATURE: Wayne R. Hershair
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Short's Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3815
Local Reg. No. 87
Reg. Dist. No. 200

BIRTH NO.

RECEIVED SEP 3 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 901 East "B"

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	H.	Berrigan	August 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	May 12, 1912	57		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Insurance 25		Troy, New York	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Patrick A. Berrigan	Ireland	Harriet Cullette	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes World War II		✗ William C. Berrigan	Wn. Sedro Wooley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1958, *to* Aug. 12, 19 69 *that I last saw the deceased alive on* Aug. 12, 19 69, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. P. Marineau, M. D. 328	129 W. Third St. Moscow, Ida.	8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	August 12, 1969	Hazen & Jaeger	Spokane Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 25, 1969	Wayne K Heiskari	NOT EMBALMED E. Pete Albertson	

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3816
Local Reg. No. 82
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 19 1969 Bureau of Vital

BIRTH NO.

1. PLACE OF DEATH 241
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 2 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Potlatch
d. STREET ADDRESS (If rural, give location): 920 Spruce St.

3. NAME OF DECEASED (Type or Print)
a. (First): BENJAMIN
b. (Middle): HENRY
c. (Last): SWATMAN

4. DATE OF DEATH (Month) (Day) (Year): August 12, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 8, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months 4, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 11
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Plankton, S. Dakota
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Milton G. Swatman — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Nina J. Smith — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW1 3
16. SOCIAL SECURITY NO.: 518-12-1237
17. INFORMANT'S OWN SIGNATURE: Ora B Swatman — ADDRESS: Potlatch, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Posterior Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Occlusion
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Complete Heart Block

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/12, 1969 *to* 8/12, 1969, *that I last saw the deceased alive on* 1PM 8/12/69 *and that death occurred at* 1:05 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas D Baird MD
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 8/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Freeze Cemetery
24d. LOCATION (City, town, or county) (State): Latah Co., Idaho

DATE REC'D BY LOCAL REG.: Aug 18 1969
REGISTRAR'S SIGNATURE: Wayne R Heishare
25. EMBALMER: H E Kimball
LICENSE NO.: E269

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Kimball Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 2 9 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 1 6 1980

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3817
Local Reg. No. 85
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 29 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Deary
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Emil		Burklund	August 16 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	August 7, 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Troy, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nils Burklund	Sweden	Anna Nilson	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-14-0070A	X Earl Burklund	Deary

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stroke — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hardening of the arteries — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 28, 1969, *to* 8-14, 1969, *that I last saw the deceased alive on* 8-13, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O Drury M.D.	Troy Idaho	8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1969	Pine Crest Cemetery	Deary Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
21 August 1969	Wayne R Hendricks	E. Pete Albertson	E-525

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3818
Local Reg. No. 89
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH — SEP 1 0 1969
a. COUNTY Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow — LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Genesee
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Peter	Kries	Aug. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Nov. 7, 1888	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Agriculture	Carroll County, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nicholas Kries	Iowa	Anna Gross	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-28-9710	X Omer Kries	Genesee, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart disease years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 16, 1969, *to* Aug 18, 1969, *that I last saw the deceased alive on* Aug 17, 1969 *and that death occurred at* 2:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D L Adams, M D	Moscow, Idaho	8/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 20, 1969	Genesee Catholic Cemetery	Genesee, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
28 August 1969	Wayne L Keskari	Donald Ward	E-380

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3819
Local Reg. No. 91
Reg. Dist. No. 200

Certificate of Death

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 17 Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 317 So. Almon

3. NAME OF DECEASED (Type or Print)
a. (First): Olive
b. (Middle): Izabelle
c. (Last): Thompson

4. DATE OF DEATH (Month) (Day) (Year): August 20 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Oct 1, 1877
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Waitsburg, Wash.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Doron Hamilton — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Martha Bronton — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-36-8171
17. INFORMANT'S OWN SIGNATURE: Albert Nicky — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — 4109

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary artery disease
DUE TO (c): Arteriosclerotic Heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Recurrent Breast cancer in right shoulder chest

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) ~~(Day)~~ ~~(Year)~~ ~~(Hour)~~ m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-9-45, 19__, *to* 8-20-69, 19__, *that I last saw the deceased alive on* 8-20-69, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph Wilson MD
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 8-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 2 Sept 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskin
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3820
Local Reg. No. 93
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Latah Nursing Home
c. LENGTH OF STAY (in this place): 8 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Moscow, Idaho 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 420 No. Washington

3. NAME OF DECEASED (Type or Print): a. (First) Lulu; b. (Middle) Laura; c. (Last) Condell

4. DATE OF DEATH: (Month) Aug (Day) 22 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: May 4, 1880

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sacramento, Cal.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Condell
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Anna Smith
BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-54-1119

17. INFORMANT'S OWN SIGNATURE: Eileen Condell
ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4489

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Senility —
DUE TO (c): General atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-27, 1958, *to* 8-22, 1969, *that I last saw the deceased alive on* 8-22, 1969, *and that death occurred at* 2:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Earl M. Dunn MD

23b. ADDRESS: Moscow Idaho

23c. DATE SIGNED: 9-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 26, 1969

24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery

24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 4 Sept 1969

REGISTRAR'S SIGNATURE: Wayne R. Heiskari

25. EMBALMER: Donald Ward

LICENSE NO.: E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 3 0 1975

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3821
Local Reg. No. 90
Reg. Dist. No. 200

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 9 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latah Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 292
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Deary
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Emily
b. (Middle) Nancy
c. (Last) Pierce

4. DATE OF DEATH (Month) August (Day) 24 (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH June 8, 1892

9. AGE (In years last birthday) 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Holding Ford, Minn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Preston Osborn
BIRTHPLACE Kansas

14. MOTHER'S MAIDEN NAME Hattie Baker
BIRTHPLACE Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-12-1817D

17. INFORMANT'S OWN SIGNATURE X Elsie Hanson
ADDRESS Moscow, Ida.

1890

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) METASTATIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CARCONOMA OF LEFT KIDNEY — 2 YEARS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. DIABETES MELLITUS

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November, 1964, *to* August, 1969, *that I last saw the deceased alive on* August 2, 1969, *and that death occurred at* 3:20 PM *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) M.D.

23b. ADDRESS MOSCOW, Idaho

23c. DATE SIGNED 27 Aug, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug 27, 1969

24c. NAME OF CEMETERY OR CREMATORY Elwood Cemetery

24d. LOCATION (City, town, or county) near Kendrick (State) Idahho

DATE REC'D BY LOCAL REG. 2 Sept 1969

REGISTRAR'S SIGNATURE Wayne R. Hendricks

25. EMBALMER Donald Ward

LICENSE NO. E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3822
Local Reg. No. 88
Reg. Dist. No. 200

RECEIVED
SEP 3 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 412 Spotswood

3. NAME OF DECEASED (Type or Print)
a. (First): Jacob
b. (Middle): Edward
c. (Last): Sweedman

4. DATE OF DEATH (Month) (Day) (Year): Aug 24 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: March 10, 1891
9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance worker
10b. KIND OF BUSINESS OR INDUSTRY: Univ. Idaho
11. BIRTHPLACE (State or foreign country): Lindville, Minn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob Sweedman
BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Louise
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-12-5478 A
17. INFORMANT'S OWN SIGNATURE: Mabel Sweedman
ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease
DUE TO (c): With Congestive Heart Failure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cerebral arteriosclerosis
Chronic Bronchopulmonary disease

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-4-, 1939, *to* 8-24-, 1969, *that I last saw the deceased alive on* 8-24-, 1969, *and that death occurred at* 800 *P.M., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. Wilson, M.D. 567
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 8-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 28 August 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

BIRTH NO. 69-9408

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3823
Local Reg. No. 100
Reg. Dist. No. 200

1. PLACE OF DEATH
a. COUNTY: Latah — SEP 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Village, Township or Precinct): Moscow
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 225½ Lieullan

3. NAME OF DECEASED (Type or Print): a. (First) Edwin — b. (Middle) Cyril — c. (Last) Rood, Jr.

4. DATE OF DEATH: (Month) Aug (Day) 28 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Aug 27, 1969

9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Moscow, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edwin Rood — BIRTHPLACE: Emmett, Ida.

14. MOTHER'S MAIDEN NAME: Ruth Ann Freund — BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: E. C. Rood — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7769

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congenital atelectasis of lungs — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-27- *, 1969, to* 8-28-69 *, 19 , that I last saw the deceased alive on* 8-27-69 *, 19 , and that death occurred at* 7:05a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. P. Marineau, M. D.

23b. ADDRESS: 129 W. Third St. Moscow, Idaho

23c. DATE SIGNED: 9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 29, 1969

24c. NAME OF CEMETERY OR CREMATORY: Moscow Catholic

24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 10 Sept 1969

REGISTRAR'S SIGNATURE: Wayne R Heiskari

25. EMBALMER: Harold Ward

LICENSE NO.: E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3824
Local Reg. No. 99
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits or rural, give township): Moscow
c. LENGTH OF STAY (in this place): 17 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
d. STREET ADDRESS (If rural, give location): Rt. 1 Box-38A

3. NAME OF DECEASED (Type or Print): a. (First) Lela b. (Middle) c. (Last) Miller

4. DATE OF DEATH: (Month) Aug. (Day) 29 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: December 20, 1885

9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Jewell County Kansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur Butzien — BIRTHPLACE: Chicago, Illinois

14. MOTHER'S MAIDEN NAME: Rosena Meyers — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-60-9570

17. INFORMANT'S OWN SIGNATURE: Marvina E. Miller — ADDRESS: Genesee, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Senile Psychosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* May 11, 1969 *to* 8-29, 1969, *that I last saw the deceased alive on* 8-28, 1969, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): LaRele J. Stephens M.D. — **23b. ADDRESS**: Moscow, Idaho — **23c. DATE SIGNED**: 9-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Sept. 1, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Genesee City Cemetery — **24d. LOCATION** (City, town, or county): Genesee (State): Idaho

DATE REC'D BY LOCAL REG.: 8 Sept 1969 — **REGISTRAR'S SIGNATURE**: Dayrel Heiskari — **25. EMBALMER**: Donald Ward — **LICENSE NO.**: E-380

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3825
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 AUG 20 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Leadore Bureau
c. LENGTH OF STAY (in this place): 24 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elby Schmidt Ranch 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Leadore
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Frank
b. (Middle): Barber
c. (Last): Raymond

4. DATE OF DEATH (Month) (Day) (Year): August 6, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 18, 1909
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ranch worker 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annis, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Pierce Raymond — BIRTHPLACE: Smithfield, Utah
14. MOTHER'S MAIDEN NAME: Elsie Irene Merrill — BIRTHPLACE: Smithfield, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 07 4472
17. INFORMANT'S OWN SIGNATURE: Wallace E Raymond — ADDRESS: Leadore, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3940

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rheumatic Heart disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Aortic & Mitral Stenosis 1 yr.
~~DUE TO (c)~~ Arteriosclerotic

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cardio Vasc disease 2 mos.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 1960, *to* Present, *that I last saw the deceased alive on* 3-26-, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W B Harhadon M 045
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 8-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial & removal
24b. DATE: Aug. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Annis
24d. LOCATION (City, town, or county) (State): Annis, Idaho

DATE REC'D BY LOCAL REG.: Aug 17th 69
REGISTRAR'S SIGNATURE: Viola E Johnson
25. EMBALMER: Delbert C Jones
LICENSE NO.: E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: JONES FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3826
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

RECEIVED AUG 20 1969

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 33 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): North Fork
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Theodore; b. (Middle) Clyde; c. (Last) Hisey

4. DATE OF DEATH (Month) (Day) (Year): Aug. 10, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 27, 1909

9. AGE (In years last birthday): 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.Forest Service

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kenton, Ohio

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Arthur Fay Hisey
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Iona Mentzer
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-20-0724

17. INFORMANT'S OWN SIGNATURE: Claire Hisey
ADDRESS: North Fork, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* March 16, 1955, *to* August 10, 1969, *that I last saw the deceased alive on* August 10, 1969, *and that death occurred at* 2:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 263
23b. ADDRESS: Box 769, Salmon, Idaho
23c. DATE SIGNED: 8/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Aug 17-69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert Jones
LICENSE NO.: E 369
FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: OCT 1 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3827
Local Reg. No. 690
Reg. Dist. No.

RECEIVED
SEP 2 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle Rock Hole at
c. LENGTH OF STAY (in this place): 20 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4th of July Creek 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salm on
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	Leslie	White	Aug. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	never married	Aug. 1, 1948	21				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
a		Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Francis Charles White	Chillicothe, Ill.	Elna Welchman	Tyhee, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-58-2098	Ena W. Rose	Salmon, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by drowning — INTERVAL BETWEEN ONSET AND DEATH: -0-

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	18	330

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Delbert C Jones 555	Lemhi Co. Coroner	Salmon, Idaho	Aug. 22, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 23, 1969	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 29th 69	Viola E. Johnson	Delbert C Jones	E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 18 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED SEP 5 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3828
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 39 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellis
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) Paul c. (Last) Bernard

4. DATE OF DEATH (Month) (Day) (Year): Aug. 20, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: March 10, 1886

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher & sheep herder

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Gaps, France

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jean Leopold Bernard
BIRTHPLACE: France

14. MOTHER'S MAIDEN NAME: Marie Elisa Baille
BIRTHPLACE: France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-36-4019A

17. INFORMANT'S OWN SIGNATURE: Clara E. Dowton
ADDRESS: May, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nephrosclerosis — 3yrs
DUE TO (c) Hypertension — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

403X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* January, 1967, *to* Aug 20, 1969, *that I last saw the deceased alive on* Aug 19, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. L. Blackadar MD 045
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Sept 3rd 69
REGISTRAR'S SIGNATURE: Viola E. Johnson

25. EMBALMER: Delbert C Jones
LICENSE NO.: E 369
FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3829
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi — SEP 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Salmon
c. LENGTH OF RESIDENCE at Place of Death: 83 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casabello Estate

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	Minerva	Tobias	Aug. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	May 20, 1867	102		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Plymouth, Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jobe Gorton — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Lucy Yearian — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 60 5709
17. INFORMANT'S OWN SIGNATURE: Maude L. Hall — ADDRESS: San Fran., Cal.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Generalized arteriosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Cerebrovascular disease

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-14, 1960, *to* 8-21-69, 19___, *that I last saw the deceased alive on* 7-30, 1969, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): M.D.
23b. ADDRESS: Box 769 Salmon, Idaho
23c. DATE SIGNED: 8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: McRea
24d. LOCATION (City, town, or county) (State): Leadore, Idaho

DATE REC'D BY LOCAL REG.: Aug 29 69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones — LICENSE NO.: E 369
FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 27 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 10 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept 12, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3830
Local Reg. No. 690
Reg. Dist. No. _____

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (In this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION: Steele Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Mabel; b. (Middle) Adele; c. (Last) Rand

4. DATE OF DEATH: (Month) August (Day) 24, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 27, 1883

9. AGE (In years last birthday): 86
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salmon, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John C. Kadletz
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Martha Jane Brock
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-54-2074

17. INFORMANT'S OWN SIGNATURE: Phyllis R. Caples
ADDRESS: Salmon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized — 6 mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1949, 19____, *to* death, 19____, *that I last saw the deceased alive on* Aug 24, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. L. Blackadar, M.D. (Degree or title)
23b. ADDRESS: Salmon, Idaho
23c. DATE SIGNED: 8-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 26, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Sept 5, 1969
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369

FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
SEP 1 1 1969
Bureau of Vital Statistics

State of Idaho
County of Lemhi } ss.

Certificate No.
Date Filed

The undersigned does solemnly swear that certificate of death
(Birth or Death)
for Mabel Adele Rand (Name on Original Certificate) who died (Was Born or Died) on Aug. 24, 1969 (Date of Event)
in Salmon, Lemhi, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by birth certificate & Bible Record (Bible Record, Insurance Policy, Etc.) prepared on shortly after birth (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Birth year	1893	1883
Age	76	86

Subscribed and sworn to before me this 8th day of Sept., 1969
Mary A. Jones
Notary Public, residing at Salmon, Idaho
My commission expires Oct. 1, 1971
(Seal)

John P. Rand Son
Signed Phyllis P. Sayles, daughter
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)
Salmon, Idaho 83467
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Lemhi } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 9th day of Sept., 19 69
Mary A. Jones
Notary Public, residing at Salmon, Idaho
My commission expires Oct. 1, 1971
(Seal)

Signed Delbert C. Jones
(Signature of Any Credible Person)
Embalmer & Funeral Director
Box 472, Salmon, Id. 83467
(Street Address, City, State)

STATE OF IDAHO

DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend Certificate of Birth or Death

State of Idaho ss. Certificate No.

County of Lemhi Date Filed

SEP 11 1969

The undersigned does solemnly swear that certificate of death (Birth or Death)

for Mabel Adele Rand (Name on Original Certificate) who died (Was Born or Died) on Aug. 24, 1969 (Date of Event)

in Salmon, Lemhi, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by birth certificate & Bible Record (Bible Record, Insurance Policy, Etc.) prepared on shortly after birth (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Birth Year	1893	1883
Age	75	86

Subscribed and sworn to before me this 8th day of Sept. 1969

Signed Lloyd B. Eagles, daughter (Signature of parent or attendant if correcting a birth record; or attendant, funeral director, informant if correcting a death record; or other credible person.)

Notary Public in and at Salmon, Idaho

My Commission Expires Oct. 1, 1971

Salmon, Idaho 83467 (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho ss.

County of Lemhi

[This Affidavit MUST Also be Executed. (See Chapter 138, 1957 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are to the best of his knowledge.

Subscribed and sworn to before me this 9th day of Sept. 1969

Signed [signature] (Signature of Any Credible Person)

Notary Public in and at Salmon, Idaho

My Commission Expires Oct. 1, 1971

Embalmer & Funeral Director

Box 472, Salmon, Id. 83467 (Street Address, City, State)

STATE OF IDAHO NOTARY PUBLIC

STATE OF IDAHO NOTARY PUBLIC

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

RECEIVED
SEP 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN: Salmon
c. LENGTH OF STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Mabel; b. (Middle) Adele; c. (Last) Rand

4. DATE OF DEATH (Month) (Day) (Year): Aug. 24, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 27, 1893

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salmon, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John C. Kadletz
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Martha Jane Brock
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-54-2074

17. INFORMANT'S OWN SIGNATURE: Mrs. R. Caples
ADDRESS: Salmon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): generalized — 6 mos.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1949, 19__, *to* death, 19__, *that I last saw the deceased alive on* Aug 24, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Markadas
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 8-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 26, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Sept 5th 69
REGISTRAR'S SIGNATURE: Viola E Johnson
25. EMBALMER: Delbert C Jones
LICENSE NO.: E 369
FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 12 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3831
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 76 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Willard	Thurstain	McCracken	Aug. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	April 15, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher and carpenter	21	Oskaloosa, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Franklin Pierce McCracken	Kansas	Emma Long	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW I	519-32-1222A	Effie Mae McCracken	Salmon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Acute Coronary

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Infarction
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1d.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1950, 19__, to death, *that I last saw the deceased alive on* Aug 27 19 69 *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W B Rankin MD	Salmon Ida	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-30-69	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 11th 69	Viola E. Johnson	Elbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 12 1969 Bureau of Vital Statistics

State File No. 3832
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN: Salmon
DURATION OF STAY (in this place): 54 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lora	Pearl	Leonard	Aug. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	May 30, 1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DD
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Turin, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Solomon Hendrick Cork	unknown	Hannah Abigail Henderson	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-07-7129A
17. INFORMANT'S OWN SIGNATURE: Lila Barnett ADDRESS: Tendoy, Id.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4241 Aortic Stenosis — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19**56**, *to* 8-28, 19**69**, *that I last saw the deceased alive on* 8-28, 1969, *and that death occurred at* 1:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. W. Moore, M.D.	Salmon, Idaho	9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 2, 1969	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 11th 69	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3833
Local Reg. No. 698
Reg. Dist. No.

RECEIVED
SEP 12 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN: Salmon
LENGTH OF STAY (in this place): 35 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location): Casabello Estate

3. NAME OF DECEASED (Type or Print): a. (First) Lawrence; b. (Middle) (none); c. (Last) Malcolm

4. DATE OF DEATH: (Month) (Day) (Year) August 31, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: April 30, 1891

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mining and ranching

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Reedy, West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sam Malcolm
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Bessie L. Malcolm
BIRTHPLACE: Salmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 01 7969A

17. INFORMANT'S OWN SIGNATURE: Catherine Stewart
ADDRESS: unknown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia -	3d.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Subdural Hematoma	15 yr.
DUE TO (c)	+ Cerebral Hemorrhage	15 yr
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: Original
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): farm
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 300 Lemhi, Lemhi, Ida
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): About 1954 m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Runaway team of horses.

22. I hereby certify that I attended the deceased from 1960, 19__, to death, that I last saw the deceased alive on Aug 31, 19 69 and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE: W. L. Blanchard M.D. (Degree or title)
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Sept 11 '69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3834
Local Reg. No. 692
Reg. Dist. No. 430

BIRTH NO.

RECEIVED AUG 12 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (in this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) c. (Last) KELLE

4. DATE OF DEATH: (Month) Aug. (Day) 1, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 1, 1889

9. AGE (In years last birthday): 80 IF UNDER 1 YEAR Months: 0 Days: 0 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railroader 10

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob Kelle BIRTHPLACE: Russia

14. MOTHER'S MAIDEN NAME: Maria Neumann BIRTHPLACE: Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 501-03-5328-A

17. INFORMANT'S OWN SIGNATURE: William Kaus ADDRESS: Shoshone, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis 4709 — INTERVAL BETWEEN ONSET AND DEATH: 5 wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 29, 1969, *to* Aug 1, 1969, *that I last saw the deceased alive on* July 29, 1969, *and that death occurred at* 5:20 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 386

23b. ADDRESS: Shoshone Idaho

23c. DATE SIGNED: 8-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-4-1969

24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery

24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 8-6-69

REGISTRAR'S SIGNATURE: Frances M. Bergin

25. EMBALMER: Frances M. Bergin LICENSE NO.: E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 1 0 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

REC AUG 12 1969 Bureau of Vital Sta

STATE OF IDAHO

State File No. 3835
Local Reg. No. 69
Reg. Dist. No. 430

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wood River Conv. Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 205 East Ave. "E"

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ANNA		HARDING	Aug. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	June 20, 1909	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Ruff, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. C. Kulm	Russia	Christina Kurtz	Romania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 50 9886	X Mrs. Bill Black	Jerome, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arthritis — 10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 21, 1969, to Aug 5, 1969, *that I last saw the deceased alive on* Aug 4, 1969, *and that death occurred at* 7:30 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Shoshone Idaho	8-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 8, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-8-69	Francis M. Bergin	W. L. Hove	E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 3 1974

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-208 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3836
Local Reg. No. 693
Reg. Dist. No. 430

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (in this place): 3 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): RETTIE
b. (Middle):
c. (Last): ADAMS

4. DATE OF DEATH (Month) (Day) (Year): Aug. 10, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 10, 1891
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months 10, Days 0 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Manes, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Cline — BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Jane Cannon — BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 519-10-1423D
17. INFORMANT'S OWN SIGNATURE: X Ruth Johansen — ADDRESS: Richfield, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1533

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Sigmoid Colon — 1½ yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1966, *to* August 10, 1969, *that I last saw the deceased alive on* August 7, 1969, *and that death occurred at* 2:55 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 386
23b. ADDRESS: Box 8 Shoshone Idaho
23c. DATE SIGNED: 8-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-14-1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 8-20-69
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

AUG 2 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3837
Local Reg. No. 692
Reg. Dist. No. 430

BIRTH NO.

AUG 22 1969

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (in this place): 8 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
PEARL	GARFIELD	BAKER	Aug.	10,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Dec. 12, 1884	84	7	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Verycruz, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rufus Morgan — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Mary Emmaline Kirkendall — BIRTHPLACE: Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-60-7752-A
17. INFORMANT'S OWN SIGNATURE: Thelma Kimble — ADDRESS: Hailey, Ida.

4379

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 11 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 10 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 12, 1958, *to* Aug 10, 1969, *that I last saw the deceased alive on* August 7, 1969, *and that death occurred at* 2:55 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 386
23b. ADDRESS: Box 6 Shoshone Idaho
23c. DATE SIGNED: 8-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-13-1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Id

DATE REC'D BY LOCAL REG.: 8-20-69
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3838
Local Reg. No. 48
Reg. Dist. No. 630

RECEIVED AUG 12 1969

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg Bur
c. LENGTH OF STAY (in this place): 2 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison County Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony, Rural
d. STREET ADDRESS (If rural, give location): RFD#1

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): A.
c. (Last): TOOLSON Jr.

4. DATE OF DEATH (Month) (Day) (Year): August 1, 1969

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Jan. 8, 1899
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer and Sheepman
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): Smithfield, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Georga A. Toolson Sr. — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Laura Raymond, — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I & WWII 4
16. SOCIAL SECURITY NO.: 518-42-8838
17. INFORMANT'S OWN SIGNATURE: Don Jackson — ADDRESS: St. Anthony, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis — several years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Pulmonary fibrosis & emphysema — 30 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 2, 1969, *to* Aug 1, 1969, *that I last saw the deceased alive on* Aug 1, 1969, *and that death occurred at* 2 A. M. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 413 Lester J. Hansen MD
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 4 August 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4 August 69
24c. NAME OF CEMETERY OR CREMATORY: Wilford Cemetery
24d. LOCATION (City, town, or county) (State): St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.: 8-8-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: M. D. Hansen — M D Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HANSEN MEMORIAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 6 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 3839
Local Reg. No. 30
Reg. Dist. No. 630

BIRTH NO.

RECEIVED STATE OF IDAHO

SEP 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 330
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg- Rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 330
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg- Rural
d. STREET ADDRESS (If rural, give location): RFD#2

3. NAME OF DECEASED (Type or Print)
a. (First): GARTH
b. (Middle): KEITH
c. (Last): ROBERTSON

4. DATE OF DEATH (Month) (Day) (Year): Aug., 10, 1969

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: April 28, 1951
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student-Laborer 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rexburg, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Keith O. J. Robertson — BIRTHPLACE: Plano, Idaho
14. MOTHER'S MAIDEN NAME: Carol Riley — BIRTHPLACE: Rigby, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-64-6898
17. INFORMANT'S OWN SIGNATURE: Keith O J Robertson — ADDRESS: Rexburg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Rural - River 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Madison 330 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 10, 1969, 5P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Drowned while swimming.

22. *I hereby certify that I attended the deceased from* Oct, 1953, *to* Aug, 1969, *that I last saw the deceased alive on* Feb 8, 1969, *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Blaine H Passeyer 409
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: 8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 13 Aug 69
24c. NAME OF CEMETERY OR CREMATORY: Plano Cemetery
24d. LOCATION (City, town, or county) (State): Rexburg, RFD#2, Idaho

DATE REC'D BY LOCAL REG.: 8/19/69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: M. D. Hansen — M D Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3840
Local Reg. No. 51
Reg. Dist. No. 630

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

SEP 2 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Archer
d. STREET ADDRESS (If rural, give location): Thornton RFD.

3. NAME OF DECEASED (Type or Print)
a. (First): Cyril
b. (Middle):
c. (Last): Weekes

4. DATE OF DEATH (Month) (Day) (Year): August 13, 1969

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 29, 1896
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sunnydell, Idaho
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Sidney Weekes — BIRTHPLACE: Welling ~~Caerleon~~, Kent, England
14. MOTHER'S MAIDEN NAME: Annie Bennett — BIRTHPLACE: Caerleon Onnouth, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-42-9676
17. INFORMANT'S OWN SIGNATURE: Ethel Rogers — ADDRESS: 1860 East 3900 So. Salt Lake City, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Prostatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1966
19b. MAJOR FINDINGS OF OPERATION: Prostate Carcinoma
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1953, *to* Aug 13, 1969, *that I last saw the deceased alive on* Aug 13, 1969, *and that death occurred at* 5:50 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Blaine H Passey MD 409
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: 8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/16/69
24c. NAME OF CEMETERY OR CREMATORY: Sutton Cemetery
24d. LOCATION (City, town, or county) (State): Archer, Madison, Idaho

DATE REC'D BY LOCAL REG.: 8-16-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Russel Flamm
LICENSE NO.: E-254

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 0 1 1991

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3841
Local Reg. No. 52
Reg. Dist. No. 630

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison — SEP 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give place): Rexburg
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CDV

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 203 West Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	Lloyd	Adams	August 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Cauc.	Widowed	April 25, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attorney		Nephi, Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Adams	Nephi, Utah	Charlotte Hyder	Nephi, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-46-0279	Madene Miller	1510 Royal Blvd Glendale, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis Hemolyzed
DUE TO (c): Right Heart Failure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 39, *to* Aug 14, 1969, *that I last saw the deceased alive on* Aug 14, 1969, *and that death occurred at* 1:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. F. Rigby M.D.	Rexburg Idaho	8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1969	Rexburg Cemetery	Rexburg, Madison, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-18-69	Leona Flamm	Russell A. Flamm	E-254

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3842
Local Reg. No. 53
Reg. Dist. No. 630

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Madison 32 SEP 2 1969
b. CITY OR TOWN Rural Dry Farms (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) OOD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Montana 27 b. COUNTY Big Horn 555
c. CITY OR TOWN Hardin (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Clyde	Henry	Francis	August	23,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Divorced	Feb. 9,1909	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Farm	Eldorado, Missouri	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur L. Francis	Kansas City, Mo.	Lillian Cox	Eda, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unk	520-03-5295		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental — 9258

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Electricution
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE: Accident Electricution
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm 04
21c. (CITY, TOWN, OR TOWNSHIP) 1 Mile W, 4½ Mile So 33c (COUNTY) Newdale, Madison (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug, 23, 69 5:40P
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Moving grain auger, Hit Power line.

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 583 4	Coroner, Madison	County, P.O. Box 13, Rexburg	25Aug69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8/25/69	Custer U.S Military Cem.	Billings, Big Horn Co. Mont.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-69	Lona Flamm	Russell Flamm	E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3843
Local Reg. No. 54
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 2 1969 331

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 405 E.1 No.

3. NAME OF DECEASED (Type or Print)
a. (First): David
b. (Middle): Patterson
c. (Last): Hunter

4. DATE OF DEATH (Month) (Day) (Year): August 27, 1969

5. SEX: Male
6. COLOR OR RACE: Caric.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 6, 1890
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Heavy Equip. Operator.
10b. KIND OF BUSINESS OR INDUSTRY: Equipment Operator.
11. BIRTHPLACE (State or foreign country): Clarkston, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Patterson Hunter
BIRTHPLACE: Clackmannon, Scotland
14. MOTHER'S MAIDEN NAME: Hilda Charolotte Malmberg
BIRTHPLACE: On The Plains of Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-07-4043
17. INFORMANT'S OWN SIGNATURE: Vivella Miller
ADDRESS: 344 Adams Twin Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Causing Intestinal Obstruction
DUE TO (c) Cholecystectomy for

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Chr. Cholecystitis & Lithiasis — 8-18-69

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Gallbladder Contained Stones
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1948, *to* Aug. 27 1969, *that I last saw the deceased alive on* 6:30 AM, 1969, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. F. Rigby M.D. 442
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: 8-28-1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/30/69
24c. NAME OF CEMETERY OR CREMATORY: Teton Newdale Cemetery
24d. LOCATION (City, town, or county) (State): Teton, Madison Idaho

DATE REC'D BY LOCAL REG.: 8-30-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Russel Flamm
LICENSE NO.: E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 24 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3844
Local Reg. No. 66
Reg. Dist. No. 450

BIRTH NO.

RECEIVED AUG 18 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 324 "A" Street

3. NAME OF DECEASED (Type or Print): a. (First) Earl; b. (Middle) T.; c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year): August 2, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 31, 1892

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher and Cattleman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Roberts, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Johnson
BIRTHPLACE: California

14. MOTHER'S MAIDEN NAME: Pauline Clifford
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.: 517-34-9508

17. INFORMANT'S OWN SIGNATURE: X Beatrice Johnson
ADDRESS: Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronomalosis — INTERVAL BETWEEN ONSET AND DEATH: 8 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): unknown. It was a
DUE TO (c): heavy smoker.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 1967, *to* Aug ____, 1969, *that I last saw the deceased alive on* 5-21-69, 19____, *and that death occurred at* ? m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ben K. Humphrey (Degree or title): MD
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 8-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: 8-15-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Charles L Parsons
LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG 12 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3845
Local Reg. No. 34
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Rupert
c. LENGTH OF STAY in this place: 22
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home Rupert

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Rupert
d. STREET ADDRESS (If rural, give location): Box 214

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Floyd	Hawley	Greer	August 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married	Sept. 21, 1908	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Mgr. 26	Seed Industry	Glasgow, Kentucky	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
W. W. Greer	Kentucky	Myrtie Bartlett	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	517-01-2344	Mrs Floyd H Greer	Rupert, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: not known

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterial sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 3, 19 69, *to* Aug 3, 19 69, *that I last saw the deceased alive on* Aug 3, 19 69, *and that death occurred at* 12:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C F Dalley M D	702 D Street Rupert Idaho 83350	8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	8/6/69	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-7-69	Mary Ellen Cashon		E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3846
Local Reg. No. 5455
Reg. Dist. No. 450

RECEIVED AUG 12 1969 Bureau of Vital

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 1217 "H" Street

3. NAME OF DECEASED (Type or Print)
a. (First): Eli
b. (Middle): G.
c. (Last): ELCOCK

4. DATE OF DEATH (Month) (Day) (Year): August 7, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: October 18, 1903
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Postal Employee
10b. KIND OF BUSINESS OR INDUSTRY: (Retired) 08
11. BIRTHPLACE (State or foreign country): Malad City, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Elcock — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Julia Gibson — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 528-01-6694
17. INFORMANT'S OWN SIGNATURE: Luella C Elcock — ADDRESS: Rupert, Idaho

4/09

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Myocardial Infarction
DUE TO (c): Arterial Sclerosis — Not known

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 17, 1969, *to* Aug 7, 1969, *that I last saw the deceased alive on* Aug 7, 1969, *and that death occurred at* 10:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C F Dalley MD 127
23b. ADDRESS: 702 G St Rupert Idaho
23c. DATE SIGNED: Aug 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: August 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Shrine of Memories Crematory
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: 8. 8. 69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Charles H Persons
LICENSE NO.: E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 4 1969

AUG 1 9 1969

SEP 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3847
Local Reg. No. 37
Reg. Dist. No. 440

BIRTH NO. 69-5117

RECEIVED AUG 18 1969

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) 400 West - 425 South

3. NAME OF DECEASED (Type or Print) a. (First) Pamela b. (Middle) Sue c. (Last) McKee

4. DATE OF DEATH (Month) (Day) (Year) August 7, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH May 30, 1969
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 2 Days 8 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked
10b. KIND OF BUSINESS OR INDUSTRY - - - - -
11. BIRTHPLACE (State or foreign country) Rupert, Idaho
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME James P. McKee
BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Ella Marie Fox
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE James P McKee ADDRESS Heyburn, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Choked on Vomitous — INTERVAL BETWEEN ONSET AND DEATH Few minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/30/69, 19__, *to* 8/7/69, 19__, *that I last saw the deceased alive on* 8/5/69, 19__, *and that death occurred at* 4:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE C F Dalley M D (Degree or title) 177
23b. ADDRESS 702 S Rupert Ida
23c. DATE SIGNED 8/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE August 9, 1969
24c. NAME OF CEMETERY OR CREMATORY RIVERSIDE Memorial Cemetery
24d. LOCATION (City, town, or county) HEYBURN IDAHO

DATE REC'D BY LOCAL REG. 8-15-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Charles L Parsons
LICENSE NO. E-494
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3848
Local Reg. No. 62
Reg. Dist. No. 450

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 27 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn rural
c. LENGTH OF STAY (in this place): hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 376 So. 450 West

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
d. STREET ADDRESS (If rural, give location): 202 So. College

3. NAME OF DECEASED (Type or Print)
a. (First): Mabel
b. (Middle):
c. (Last): Burch

4. DATE OF DEATH (Month) (Day) (Year): Aug. 8, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 23, 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months 5, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Basin, Cassia County, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME / BIRTHPLACE: Emulous Sanford, St. Lawrence Co. N.Y
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Catherine Emma Cloward, Bear Creek, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: 518-60-8577
17. INFORMANT'S OWN SIGNATURE: Raymond F Burch — ADDRESS: Heyburn

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Gen arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 14, 1967, *to* Aug 8, 1969, *that I last saw the deceased alive on* May 3, 1969, *and that death occurred at* 11:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W R Petersen MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Aug. 11, 1969
24c. NAME OF CEMETERY OR CREMATORY: Oakley Cemetery
24d. LOCATION (City, town, or county) (State): Oakley, Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Mary Ellen Casslin PHN
25. EMBALMER: Ormand F Burch
LICENSE NO.: E471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3849
Local Reg. No. 58
Reg. Dist. No. 450

BIRTH NO.

RECEIVED AUG 18 1969

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1141 8th street Rupert 222

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 1141 8th street

3. NAME OF DECEASED (Type or Print) a. (First) NED b. (Middle) D. c. (Last) STOCKS

4. DATE OF DEATH (Month) (Day) (Year) August 9 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 30 1922

9. AGE (In years last birthday) 47
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher 12

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Preston Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Stocks — BIRTHPLACE Lewiston Utah

14. MOTHER'S MAIDEN NAME Vennie Dopp — BIRTHPLACE Lewiston Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 529-38-6026

17. INFORMANT'S OWN SIGNATURE X Mrs Ned Stocks — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetic Vascular disease and > 30 yrs
DUE TO (c) severe hypertension due to

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Nephritis — 2 yrs ±

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 1968, *to* Aug 9, 1969, *that I last saw the deceased alive on* Aug 9, 1969, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Ben K. Humphrey MD 253

23b. ADDRESS Rupert Idaho

23c. DATE SIGNED 8-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug 13 1969

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) Rupert Idaho (State)

DATE REC'D BY LOCAL REG. 8-15-69

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Robert C Walk — LICENSE NO. E294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 5 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3850
Local Reg. No. 60
Reg. Dist. No. 450

RECEIVED AUG 20 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Minidoka Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah
b. COUNTY: Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salt Lake City
d. STREET ADDRESS (If rural, give location): 1029 West First South

3. NAME OF DECEASED (Type or Print): a. (First) George b. (Middle) Joseph c. (Last) TORREZ

4. DATE OF DEATH: (Month) Aug. (Day) 13, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White (Mexican)

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: October 2, 1921

9. AGE (In years last birthday): 47
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Rawlins, Wyoming

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jose Raymon Torrez
BIRTHPLACE: New Mexico

14. MOTHER'S MAIDEN NAME: Lenora Tafoya
BIRTHPLACE: New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 523-14-7712

17. INFORMANT'S SIGNATURE: Georgia Torrez
ADDRESS: Salt Lake City,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) This man was a known diabetic, with a history of coronary occlusion, was under the

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) care of Dr Clyde Null, salt Lake City Utah he died while in a diabetic coma, had been
DUE TO (c) drinking heavy, lack of insulin, and probable coronary attack.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): at home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rupert Minidoka County Idaho

21d. TIME OF INJURY: (Month) Aug (Day) 13 (Year) 69 (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did not see alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert E Walk (Degree or title): Coroner
23b. ADDRESS: 710 6th street Rupert Idaho
23c. DATE SIGNED: 8-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Aug. 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Deseret Mortuary
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: 8-19-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson

25. EMBALMER: Robert E Walk
LICENSE NO.: E 294
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 11 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 25 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 17 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

DEC 2 1969

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

JAN 8 1970

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

MAR 17 1970

(d) Alter a certificate on file in the office of a local registrar.

JUN 10 1970

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

OCT 24 1973

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3851
Local Reg. No. 67
Reg. Dist. No. 402

RECEIVED SEP 1 5 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY IN THIS PLACE 11 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 1302 "E" Street

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kathryn's Rest Home

3. NAME OF DECEASED (Type or Print) a. (First) FRED b. (Middle) c. (Last) STRAUB

4. DATE OF DEATH (Month) (Day) (Year) August 16, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH December 11, 1898

9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Stockman

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Scottland, South Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Emanuel Straub BIRTHPLACE Russia

14. MOTHER'S MAIDEN NAME Katherine Meiland BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — — —

16. SOCIAL SECURITY NO. 504-03-5433

17. INFORMANT'S OWN SIGNATURE Reinhold Bossert ADDRESS Rupert, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) A.S.C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Dec, 1965 *to* Aug 16, 1969, *that I last saw the deceased alive on* July 22, 1969, *and that death occurred at* ? m., *from the causes and on the date stated above.*

23a. SIGNATURE Ben K. Humphrey (Degree or title) MD

23b. ADDRESS Rupert Idaho

23c. DATE SIGNED 8-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 20, 1969

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert, Idaho

DATE REC'D BY LOCAL REG. Sept 2, 1969

REGISTRAR'S SIGNATURE Mary Ellen Larson

25. EMBALMER Charles D. Persons

LICENSE NO. E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3852
Local Reg. No. 63
Reg. Dist. No. 450

Certificate of Death

RECEIVED
AUG 27 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
c. LEGAL HOME OF STAY (in this place): 31 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. # 1 ocr

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Jonathan
b. (Middle): Wesley
c. (Last): Andersen

4. DATE OF DEATH (Month) (Day) (Year): Aug. 19, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov. 3, 1887
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Brigham City, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Jonathan Andersen-Brigham City, Ut.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Ellen Tingey - Bountiful, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 518-40-9474
17. INFORMANT'S OWN SIGNATURE: Charlotte Andersen — ADDRESS: Heyburn, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary atherosclerosis ? with Hypertension
~~DUE TO (c)~~

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: none

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1963, 19__, *to* 8-19-, 1969, *that I last saw the deceased alive on* D.O.A., 19__, *and that death occurred at* 6:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R P Sutton MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 8/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Heyburn, Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Mary Ellen Carbon
25. EMBALMER: Keith Sayer
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3853
Local Reg. No. 65
Reg. Dist. No. 450

BIRTH NO.

RECEIVED AUG 28 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 5 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 300 north 276 west

3. NAME OF DECEASED (Type or Print): a. (First) Jessica; b. (Middle) M.; c. (Last) Sullivan

4. DATE OF DEATH (Month) (Day) (Year): Aug 23 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov 14 1883

9. AGE (In years on last birthday): 85 | If UNDER 1 YEAR: Months / Days | If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Brooklyn New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew I Scully — BIRTHPLACE: Dublin Ireland

14. MOTHER'S MAIDEN NAME: Margaret Emery — BIRTHPLACE: Diblin Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 135 10 6230

17. INFORMANT'S OWN SIGNATURE: Elizabeth M. Van Ewen — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): diabetic vascular neuropathy
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Post Cerebrovascular accident.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Aug 23, 1967, *that I last saw the deceased alive on* Aug 23, 1969, *and that death occurred at* 7:05 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: W Crawford MD — (Degree or title)
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 26 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 28 1969
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: 8-26-69
REGISTRAR'S SIGNATURE: Mary Ellen Barton

25. EMBALMER: Robert L Walk — LICENSE NO.: E 299
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3854
Local Reg. No. 63
Reg. Dist. No. 450

RECEIVED Bureau of Vital Statistics SEP 2 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Mem. Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 1224 8th. St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Walter	Holsten	August 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	July 8, 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 22	Gen. Merchant	Lund, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Holsten	Sweden	Christinna Gnderson	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	* No *	518-60-3762-J	Burel Holsten	Heyburn, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) hepatic failure — INTERVAL BETWEEN ONSET AND DEATH 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cirhosis — 1 year.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-28, 19 68, *to* 8-25, 19 69, *that I last saw the deceased alive on* 8-24-69 19, *and that death occurred at* 1⁰⁰ A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Ben K. Humphrey 293 (Degree or title) MD	Rupert Idaho	8-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/28/69	Riverside Cemetery	Heyburn, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-29-69	Mary Ellen Cahoon	Jerry K. Lawson	E-522

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Payne Mortuary-Burley

DUTIES:

SEP 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 9 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3855
Local Reg. No. 275
Reg. Dist. No. 220

BIRTH NO.

RECEIVED AUG 15 1969 Bureau of

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): USUAL RESIDENCE

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3420 - 16th Street

3. NAME OF DECEASED (Type or Print)
a. (First): STELLA
b. (Middle): JULIA
c. (Last): ESTES

4. DATE OF DEATH (Month) (Day) (Year): 1 August 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 31 Jan 1919

9. AGE (In years last birthday): 50
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Aztec, New Mexico

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Potter
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Mary Bowen
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 518 52 5048

17. INFORMANT'S OWN SIGNATURE: Arthur Estes
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart Dis — Years.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct. 17, 1958, *to* May 4, 19 69 *that I last saw the deceased alive on* May 4, 1969, *and that death occurred at* 4 a.m.-m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard M. Ellard MD
23b. ADDRESS: 1522 17th St Lewiston
23c. DATE SIGNED: 8-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5 Aug. 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-12-69
REGISTRAR'S SIGNATURE: Leonard Dalzen
25. EMBALMER: W E Black
LICENSE NO.: E-426
FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3856
Local Reg. No. 2876
Reg. Dist. No. 220

BIRTH NO.

RECEIVED
AUG 15 1969
Bureau

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Craigmont
d. STREET ADDRESS (If rural, give location): rural

3. NAME OF DECEASED (Type or Print): a. (First) WINFRED b. (Middle) WILLIAM c. (Last) RIGGERS

4. DATE OF DEATH (Month) (Day) (Year): 1 August 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 25 Feb 1905

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Stock & Grain

11. BIRTHPLACE (State or foreign country): Nezperce, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred Riggers
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Ernestine Koepp
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: no record

17. INFORMANT'S OWN SIGNATURE: Beryle Riggers
ADDRESS: Craigmont, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1/24/69

19b. MAJOR FINDINGS OF OPERATION: Carcinoma Urinary Bladder

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/5 1969, *to* 8/1, 1969, *that I last saw the deceased alive on* 7/31, 1969, *and that death occurred at* 5:05 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Leott M.D.

23b. ADDRESS: Lewiston Ida

23c. DATE SIGNED: 8/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 5 Aug 1969

24c. NAME OF CEMETERY OR CREMATORY: I.O.F. Cemetery

24d. LOCATION (City, town, or county) (State): Craigmont, Lewis Co., Idaho

DATE REC'D BY LOCAL REG.: 8-6-69

REGISTRAR'S SIGNATURE: Glenara Walzer

25. EMBALMER: W E Black

LICENSE NO.: E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 23 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 14 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3857
Local Reg. No. 2957
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchards Nursing Home 170

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 212 - 5th Street

3. NAME OF DECEASED (Type or Print)
a. (First) ROY
b. (Middle) CHESTER
c. (Last) WOODRUFF

4. DATE OF DEATH (Month) (Day) (Year) 2 August 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	21 Jan 1882	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retail 22	News Stand	Paris, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Woodruff	no record	Emma V Beals	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 03 2083
17. INFORMANT'S OWN SIGNATURE Mrs Wallace Bone ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stroke — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1959 19__, *to* 8/2, 1969, *that I last saw the deceased alive on* 8/4, 1969, *and that death occurred at* 8:15 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L Evenson MD	St Johns Way	8/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7 Aug 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-12-69	Leonard Dalzen	W E Black	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

AUG 25 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 17 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 26 1982

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3858
Local Reg. No. 53
Reg. Dist. No. 210

BIRTH NO.

RECEIVED AUG 18 1969

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp. 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): 233 Johnson Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): WALTER
b. (Middle):
c. (Last): SEWELL

4. DATE OF DEATH (Month) (Day) (Year): Aug. 4, 1969

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: May 4, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): barber 21
10b. KIND OF BUSINESS OR INDUSTRY: barber
11. BIRTHPLACE (State or foreign country): Willard, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William D. Sewell — BIRTHPLACE: Mo.
14. MOTHER'S MAIDEN NAME: Martha Manning — BIRTHPLACE: Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-24-4444
17. INFORMANT'S OWN SIGNATURE: X William T. Cole — ADDRESS: Weippe

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarct

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Coronary Thrombosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* Aug 4, 1969, *that I last saw the deceased alive on* Aug 3, 1969, *and that death occurred at* 2:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John Armstrong 013 MD
23b. ADDRESS: 307 St Johns Way
23c. DATE SIGNED: 8/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: August 15, 1969
REGISTRAR'S SIGNATURE: Fern M. Burger
25. EMBALMER: Lyle A. Strittmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

AUG 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3859
Local Reg. No. 2079
Reg. Dist. No. 220

BIRTH NO.

RECEIVED AUG 15 1969

1. PLACE OF DEATH
a. COUNTY: 35 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Bureau
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 124-W-18th Ave

3. NAME OF DECEASED (Type or Print): a. (First) Elmer; b. (Middle); c. (Last) Bidne

4. DATE OF DEATH: (Month) Aug (Day) 7 (Year) 1969

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 28, 1903

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired 28

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mayville, N.D.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ole Bidne
BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: No Record
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-09-5615

17. INFORMANT'S OWN SIGNATURE: X Eva M. Bidne
ADDRESS: Lewiston, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 30-45 minutes.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease. — 5+ years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov. 67, 19__, *to* Aug. 69, 19__, *that I last saw the deceased alive on* 7 Aug., 19 69, *and that death occurred at* 12 30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: B R Stein (Degree or title): M.D.
23b. ADDRESS: Lewiston Idaho.
23c. DATE SIGNED: 8 [illegible] 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-9-69
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 8-8-69
REGISTRAR'S SIGNATURE: Elmara Walzer
25. EMBALMER: Andrew F. Vassar
LICENSE NO.: E315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3860
Local Reg. No. 393
Reg. Dist. No. 220

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NezPerce 35 SEP 2 1969
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (In this place) 8-7-69
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 631 Preston Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Peter
b. (Middle) n/m/n
c. (Last) Terway

4. DATE OF DEATH (Month) (Day) (Year) 8 August 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH April 11, 1882

9. AGE (In years last birthday) 87
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 17

10b. KIND OF BUSINESS OR INDUSTRY Potlatch Forest Inc

11. BIRTHPLACE (State or foreign country) Amsterdam, Holland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Willeml Terwee — BIRTHPLACE Zaandam, Holland

14. MOTHER'S MAIDEN NAME Katherine Noomenl — BIRTHPLACE Zaandam, Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 01 1779

17. INFORMANT'S OWN SIGNATURE Helen Waldahl — ADDRESS Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congestive Heart Failure	3d.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	1++ yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus - grade T Recent amputation - left leg.	1+ year. 4 mo.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 August, 1969, *to* 8 August, 1967, *that I last saw the deceased alive on* 8 August, 1967, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE B R Stein (Degree or title) MD

23b. ADDRESS Lewiston Idaho

23c. DATE SIGNED 12 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE August 11, 1969

24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Gardens

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 8-19-69

REGISTRAR'S SIGNATURE Glenara Walzen

25. EMBALMER W.E. Black

LICENSE NO. E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 10 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3861
Local Reg. No. 209
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 15 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 7 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 922-15th Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clearwater
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Rosa
b. (Middle): Lee
c. (Last): York

4. DATE OF DEATH (Month) (Day) (Year): August 9, 1969

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 30, 1895
9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wife · Mother
10b. KIND OF BUSINESS OR INDUSTRY: Farm home
11. BIRTHPLACE (State or foreign country): Durango Colorado
12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Eugene Augustus Brown
BIRTHPLACE: Freemont, Ohio
14. MOTHER'S MAIDEN NAME: Carrie Noteware
BIRTHPLACE: Chemung Co. New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 518-64-0289
17. INFORMANT'S OWN SIGNATURE: Carey York
ADDRESS: Clearwater, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): metastatic carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 8 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 14 JAN 69
19b. MAJOR FINDINGS OF OPERATION: carcinoma of colon c̄ metastases
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 13 Jan, 1969, *to* 9 Aug, 1969, *that I last saw the deceased alive on* 9 July, 1969, *and that death occurred at* 6:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David W. Heusinkvelt
23b. ADDRESS: 302 St. John's Way
23c. DATE SIGNED: 11 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 12 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memorial
24d. LOCATION (City, town, or county): Lewiston (State): Idaho

DATE REC'D BY LOCAL REG.: 8-11-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: Patrick Mahoney
LICENSE NO.: E-495

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Trenary Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 14 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3862
Local Reg. No. 2992
Reg. Dist. No. 220

Certificate of Death

RECEIVED
SEP 2 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 wk.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 917 Preston Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): ETHEL
b. (Middle): D.
c. (Last): SALISBURY

4. DATE OF DEATH (Month) (Day) (Year): 12 August 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 31 May 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Elgin, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John M. Darr — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Margaret E. Higgenbotham — BIRTHPLACE: Ky.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 54 4449
17. INFORMANT'S OWN SIGNATURE: Carol A. Hines — ADDRESS: P.O. Box 298 Lynnwood, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5310

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Gastric ulcer — yrs

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* APR, 1967, *to* AUG 12, 1969, *that I last saw the deceased alive on* AUG 12, 1969, *and that death occurred at* 11:05 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John Arms Jr. 013
23b. ADDRESS: 307 St John's Lewiston Idaho
23c. DATE SIGNED: 8/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 14 Aug. 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 5 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED — STATE OF IDAHO

State File No. 3863
Local Reg. No. 213
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce — SEP 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY IN THIS PLACE: Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 226-3rd Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 226-3rd St.

3. NAME OF DECEASED (Type or Print): a. (First) Harry — b. (Middle) B — c. (Last) Fry

4. DATE OF DEATH (Month) (Day) (Year): August 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married	Nov. 2, 1886	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	shop	Ayr, Nebraska	U. S. A.

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
no record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE — ADDRESS
yees WW I	no record	X Mrs. Jannie E. Fry — Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Obstructive Lung Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1967, 19___, *to* 1968, 19___, *that I last saw the deceased alive on* ____, 1968, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen M. Cochrane MD 649	Lewiston	8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 16, 1969	Lewis-Clark Memorial	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-22-69	Elinor Dalzen	V. Vassar	E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

One Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3864
Local Reg. No. 216
Reg. Dist. No. 220

BIRTH NO. 69-6237

RECEIVED

Certificate of Death

STATE OF IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Nez Perce 351 SEP 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston | LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1412 Alder Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HAROLD	EDWARD	JENSEN(II)	14 August 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	21 June 1969	- - - -	1	23	- -	- -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Lewiston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William E. Jensen	Washington	Violet I. Carr	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	X William E. Jensen	Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) "Crib Death" — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Virus Pneumonia — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* - - - - - - 19 - -, *to* - - - - - - 19 - -, *that I last saw the deceased alive on* - - - - - - 19 - -, *and that death occurred at* 2:25 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wilfred J. Duclos 583 Coroner	Lewiston, Idaho	15 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	16 Aug 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-69	Alvara Dalzen	W. E. Black	W. E. Black E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES: SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 2 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3865
Local Reg. No. 219
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 5 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sommerville Nursing Home 131

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 930 Burrell Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Dixon
b. (Middle): Horton
c. (Last): Brown

4. DATE OF DEATH (Month) (Day) (Year): August 15, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: August 17, 1886
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Jefferson, North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Asa Brown — BIRTHPLACE: North Carolina
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 518-12-1515
17. INFORMANT'S OWN SIGNATURE: Monte W Brown — ADDRESS: Box 1630 Redding, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Infirmities of age
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* 5/28, 1969, *and that death occurred at* 10:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. F. Black, M.D.
23b. ADDRESS: 307 St Johns Way Lewiston
23c. DATE SIGNED: 8/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 18 Aug. 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Gardens
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W. E. Black RX — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3866
Local Reg. No. 3920
Reg. Dist. No. 320

RECEIVED
SEP 2 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1027-11th Avenue

3. NAME OF DECEASED (Type or Print) a. (First) Mabel b. (Middle) c. (Last) Mitchell
4. DATE OF DEATH (Month) (Day) (Year) August 16, 1969
5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Jan. 4, 1888
9. AGE (In years last birthday) 81 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 67
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Peobody, Kansas
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Isaac Mitchell BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME no record BIRTHPLACE no record
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no record
17. INFORMANT'S OWN SIGNATURE R. Perkins ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) cerebrovascular accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 23, *19* 69, *to* Aug. 16, *19* 69, *that I last saw the deceased alive on* Aug. 16, *19* 69, *and that death occurred at* 7:40a *m., from the causes and on the date stated above.*

23a. SIGNATURE R. Perkins MD (Degree or title) 502
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 8-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify) removal
24b. DATE Aug. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY Caldwell, Idaho
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. 8-17-69
REGISTRAR'S SIGNATURE Glenna Dalgen
25. EMBALMER Andrew F. Vassar
LICENSE NO. E315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 14 1997

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 22 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3867
Local Reg. No. 227
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 8-14-69
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Manor Nursing Home 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) P.O. Box - 32

3. NAME OF DECEASED (Type or Print)
a. (First) Allie
b. (Middle) Marie
c. (Last) Parkins

4. DATE OF DEATH (Month) (Day) (Year) August 17, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH February 22, 1883
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR Months 6 Days 4 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Kearney, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjamin Bailey — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Sarah Swain — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-9361 JX1
17. INFORMANT'S OWN SIGNATURE Norman R. Parkins — ADDRESS 1212-11th St. Clarkston, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congestive Heart Failure

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Infirmities of age

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1962, *to* Aug, 1969, *that I last saw the deceased alive on* Aug 14, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE R. D. Stover 501 (Degree or title) MD
23b. ADDRESS 939 Bryden Ave. Lew
23c. DATE SIGNED 8/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 19 Aug 1969
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 9-2-69
REGISTRAR'S SIGNATURE Glenara Dalzen
25. EMBALMER W. E. Black
LICENSE NO. E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3868
Local Reg. No. 214
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 128 St. Joseph's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: ~~Nez Perce~~ Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 308-7th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Melvin
b. (Middle): D.
c. (Last): Eads

4. DATE OF DEATH (Month) (Day) (Year): Aug. 18, 1969

5. SEX: Male ~~female~~
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 17, 1885
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor 11
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME — BIRTHPLACE: Jackson Eads
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 531-18-3509A
17. INFORMANT'S OWN SIGNATURE — ADDRESS: N. Eileen Henry — Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5321

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Peritonitis

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Perforated Peptic Ulcer Duodenum
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Pancreatitis
old Coronary Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Lewiston Nez Perce Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 15, 1969, *to* 8 18, 1969, *that I last saw the deceased alive on* 8 18, 1969, *and that death occurred at* ? m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henson 114 M D
23b. ADDRESS: St Johns Day Lewiston
23c. DATE SIGNED: 8 19 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: August 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: N rmal Hill cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-22-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN1 2 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3869
Local Reg. No. 318
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 2 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3420 - 10th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Ira
b. (Middle): Lawrence
c. (Last): Wilson

4. DATE OF DEATH (Month) (Day) (Year): August 18, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 2 1903
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months 4, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Sexton 06
10b. KIND OF BUSINESS OR INDUSTRY: Cemetery
11. BIRTHPLACE (State or foreign country): Bartlett, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lafayette Wilson — BIRTHPLACE: Monona, Iowa
14. MOTHER'S MAIDEN NAME: Sadie Lawrence — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 548-03-0919-A
17. INFORMANT'S OWN SIGNATURE: Beaulah E. Wilson — ADDRESS: Same

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Pancreas c̄ carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: March 69
19b. MAJOR FINDINGS OF OPERATION: Carcinomatosis
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1969, *to* 8-18, 1969, *that I last saw the deceased alive on* 8-18, 1969, *and that death occurred at* 24 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 874 MD
23b. ADDRESS: 628 5th Ave.
23c. DATE SIGNED: 8/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 21, 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Gardens
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-25-69
REGISTRAR'S SIGNATURE: Glenard Walzen
25. EMBALMER: W.E. Black [signature]
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 2 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3870
Local Reg. No. 222
Reg. Dist. No. 220

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Nez Perce 35 SEP 8 1969
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY IN (this place) 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 825 Warner Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) ELMER
b. (Middle) ELLSWORTH
c. (Last) MONTGOMERY

4. DATE OF DEATH (Month) (Day) (Year) 20 Aug 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 28 July 1899

9. AGE (In years last birthday) 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 83

10b. KIND OF BUSINESS OR INDUSTRY Civil

11. BIRTHPLACE (State or foreign country) Grangeville, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Owen W. Montgomery
BIRTHPLACE Oregon

14. MOTHER'S MAIDEN NAME Estella Irene Myers
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 20 0098

17. INFORMANT'S OWN SIGNATURE Evelyn E. Montgomery
ADDRESS Lewiston, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ? Strangulated inguinal hernia — INTERVAL BETWEEN ONSET AND DEATH: ? days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) peritonitis — days.
DUE TO (c) septicemia — days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES XXX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/1 *19*61, *to* 8/20, *19*69, *that I last saw the deceased alive on* 8/20, *19*69, *and that death occurred at* 9:45 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE George Alden Thompson 531 (Degree or title) M.D.

23b. ADDRESS 717 - 6th St Lewiston Ida

23c. DATE SIGNED 8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 23 Aug 1969

24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 9-2-69

REGISTRAR'S SIGNATURE Glenna Dalzen

25. EMBALMER W E Black

LICENSE NO. E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3871
Local Reg. No. 237
Reg. Dist. No. 220

Certificate of Death

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 37
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 509 Miller

3. NAME OF DECEASED (Type or Print)
a. (First): Olaf V. Carlson
b. (Middle):
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): August 21, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Nov. 5, 1895
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: general
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: no record
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: no record
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 09 4270A
17. INFORMANT'S OWN SIGNATURE: V. Vassar
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3039

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Alcoholic toxemia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1966, *to* August, 1969, *that I last saw the deceased alive on* August 21, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 083 John E. Carlson
23b. ADDRESS: 9th and Main Street, Lewiston, Idaho 83501
23c. DATE SIGNED: 9/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-8-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3872
Local Reg. No. 223
Reg. Dist. No. 220

RECEIVED Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35 SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 6 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 617A Lindsay Creek Rd.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	AMY	LILLIAN	HARRISON	21 August 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	28 Jan 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	Own Home	Hansen Ferry, Was.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Hansen	Iowa	Bertha Mason	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518 40 8282	Thelma Jane Clay	Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1966 *to* August, 1969, *that I last saw the deceased alive on* August 21, 1969, *and that death occurred at* 10:20 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
833 John E Cousins	9th and Main Street Lewiston, Idaho 83501	8/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	23 Aug 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-2-69	Elnard Dalzen	W E Black	E 426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3873
Local Reg. No. 230
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 357
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
c. LENGTH OF STAY (in this place): 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 357
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
d. STREET ADDRESS (If rural, give location): 1014-Burrell

3. NAME OF DECEASED (Type or Print): a. (First) Clara b. (Middle) [illegible] c. (Last) Weisgerber

4. DATE OF DEATH (Month) (Day) (Year): August 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	July 1, 1882	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Germany	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ludwig Waldman	Germany	no record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		none	[illegible] Weisgerber	Lewiston, Idaho

4367

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro vascular accident & coma. — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* [illegible], 19[illegible], *to* Aug., 1969, *that I last saw the deceased alive on* July, 1969, *and that death occurred at* 4:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B R Stein MD	Lewiston Idaho	25 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	8/23/69	Normal Hill cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-8-69	Elenora Dalzen	V. Vassar	E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3874
Local Reg. No. 220
Reg. Dist. No. 220

BIRTH NO.

RECEIVED
SEP 2 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington
b. COUNTY: Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Anatone
d. STREET ADDRESS (If rural, give location): 6 Miles from town

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lawrence	Henry	Huber	August 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	6-4-1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher	Cattle	Anatone, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Huber	Not Known	Gertrude Ryser	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - - - - - - - -	533 36 3888	Norma Ramsden	Anatone, Wash

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary laceration + hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractured ribs - right chest. — 6 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
1	on Ranch - 04	Anatone 48555 Asotin Washington

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug 18 1969 2 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Horse stumbled on trail, kicked him in chest while getting up.

22. *I hereby certify that I attended the deceased from* Feb., 19 53, *to* August, 19 69, *that I last saw the deceased alive on* 25 aug., 19 69, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Lewiston Idaho	25 aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	8-25-1969	Vineland	Clarkston, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-26-69	Glenna Walgen	[signature]	FD 5

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Merchant Funeral Home

DUTIES: SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3875
Local Reg. No. 223
Reg. Dist. No. 220

69-8477 BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as 'unknown' only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce — SEP 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lapwai
d. STREET ADDRESS (If rural, give location): P O Box - 29

3. NAME OF DECEASED (Type or Print): a. (First) Baby Boy — b. (Middle) — c. (Last) MC CONVILLE

4. DATE OF DEATH: (Month) (Day) (Year): 25 August 1969

5. SEX: Male

6. COLOR OR RACE: Ame. Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 24 Aug 1969

9. AGE (In years last birthday): - | IF UNDER 1 YEAR Months: - | Days: 1 | IF UNDER 24 HRS. Hours: 10 | Min.: 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Lewiston, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Syrveneas McConville — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Darlene Shippingtower — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Marlene McConville — ADDRESS: Lapwai, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 727X

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____ *and that death occurred at* 1:25 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) M.D.

23b. ADDRESS: 626 - 5th Ave. Lewiston

23c. DATE SIGNED: 8-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 27 Aug 1969

24c. NAME OF CEMETERY OR CREMATORY: Scott Family Cemetery

24d. LOCATION (City, town, or county) (State): NezPerce Co. (Cherrylanes) Idaho

DATE REC'D BY LOCAL REG.: 9-2-69

REGISTRAR'S SIGNATURE: Alenora Dalzen

25. EMBALMER: W E Black

LICENSE NO.: E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3876
Local Reg. No. 226
Reg. Dist. No. 220

RECEIVED SEP 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Somerville Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3715 - 16th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ALBERT	GREGORY	HARVEY	26 August 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	15 June 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Lumbering & Oil	Eau Claire, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eugene Harvey	Wisc.	Mary Ryan	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	516 01 6740	Fern M. McAllister	Lewiston Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 3427 Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Parkinsons Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11/22 *19*68 *to* 8/26 *, 19*69*, that I last saw the deceased alive on* 8/26 *, 19*69*, and that death occurred at* 12:20 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ron Brower, M.D	939 Bryden Lewiston Ida	30 Aug '69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	29 Aug 1969	Lewis-Clark Memo. Gard.	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-2-69	Elnora Walzer	W E Black	E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3877
Local Reg. No. 233
Reg. Dist. No. 220

RECEIVED SEP 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1307 - Birch Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Betty; b. (Middle) Louise; c. (Last) Groseclose

4. DATE OF DEATH: (Month) (Day) (Year): August 27, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 26 December 1935

9. AGE (In years last birthday): 33
IF UNDER 1 YEAR: Months: 8; Days: 1
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator 09

10b. KIND OF BUSINESS OR INDUSTRY: Pacific N/W Bell

11. BIRTHPLACE (State or foreign country): Grand &Coulee, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Virgil Byford
BIRTHPLACE: Auburn, Washington

14. MOTHER'S MAIDEN NAME: Henrietta Hawkins
BIRTHPLACE: Lewistown, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: James T Groseclose
ADDRESS: same as above

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1990

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): pulmonary edema
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): metastatic cancer
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb.24, 19 69, *to* Aug.27, 19 69, *that I last saw the deceased alive on* Aug.27, 19 69, *and that death occurred at* 1:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Lewiston, Idaho

23c. DATE SIGNED: 9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 30 Aug. 1969

24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Gardens

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-9-69

REGISTRAR'S SIGNATURE: Leonard Wolzen

25. EMBALMER: W.E. Black

LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

SEP 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3878
Local Reg. No. 232
Reg. Dist. No. 220

RECEIVED
Bureau of Vital Statistics
SEP 15 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN: Lewiston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1822 2nd Ave. North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1822 2nd Ave. N.

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) W c. (Last) DUNHAM

4. DATE OF DEATH (Month) (Day) (Year): August 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	married	Nov. 9, 1874	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R ncher
10b. KIND OF BUSINESS OR INDUSTRY: cattle
11. BIRTHPLACE (State or foreign country): Walla, Walla, Washington
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Dunham — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No record
17. INFORMANT'S OWN SIGNATURE: X [signature] ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 4 years
DUE TO (c) Uremia — 1 month

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-9-69, 19___, *to* 8-28, 19 69, *that I last saw the deceased alive on* 8-27, 19 69, *and that death occurred at* 9:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Lewiston Idaho	9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 2, 1969	Lewis-Clark Memorial Garden	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-8-69	Glenna Dalzen	V. Vassar	E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3879
Local Reg. No. 234
Reg. Dist. No. 220

Certificate of Death

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 507 Linden

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIE
b. (Middle): MAE
c. (Last): DURST

4. DATE OF DEATH (Month) (Day) (Year): 29 August 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9 March 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewiper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Chareton Co., Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Pierce — BIRTHPLACE: no/record
14. MOTHER'S MAIDEN NAME: Margaret Ann Stephens — BIRTHPLACE: no/record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 03 0656-D
17. INFORMANT'S OWN SIGNATURE: X [signature] — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2022

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, chemical due to aspiration — INTERVAL BETWEEN ONSET AND DEATH: 2 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Occlusion Diaphragm
DUE TO Radiation therapy for lymphoma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. J Mediastinum

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/15, 1969, *to* 8/28, 1969, *that I last saw the deceased alive on* 8/28, 1969, *and that death occurred at* 8:52 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 562 (Degree or title)
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED: 9/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2 Sept 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-9-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W. E. Black — W E Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3880
Local Reg. No. 237
Reg. Dist. No. 220

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3606 - 13th Street

3. NAME OF DECEASED (Type or Print): a. (First) FLORA b. (Middle) MARGARET c. (Last) HARRIS

4. DATE OF DEATH: (Month) 30 August (Day) (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 21 Sept 1887

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 57

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Granite Falls, Minnesota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Sidney Stubbs
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Mary Garlon
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 518 05 2777

17. INFORMANT'S OWN SIGNATURE: Lula Harbison
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5273 Terminal Bronchial Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Abscess L Parotid Gland

DUE TO (c) Senile Dementia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Infirmities of age

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1966 *to* Aug 1969, *that I last saw the deceased alive on* ____ 19____, *and that death occurred at* 9:35 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: R M Stover (Degree or title) M.D.

23b. ADDRESS: 939 Bryden - Lewiston

23c. DATE SIGNED: 3 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 3 Sept 1969

24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-9-69

REGISTRAR'S SIGNATURE: Glenna Dalzen

25. EMBALMER: W.E. Black W E Black

LICENSE NO.: E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filing out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 3881
Local Reg. No. 227
Reg. Dist. No. 220

BIRTH NO.

RECEIVED STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 35 — SEP 3 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital 108

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48 — b. COUNTY: Asotin 003
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 508 Sycamore

3. NAME OF DECEASED (Type or Print): a. (First) CECIL — b. (Middle) L. — c. (Last) MILES

4. DATE OF DEATH: (Month) August (Day) 30 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Feb. 2, 1909

9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed 28

10b. KIND OF BUSINESS OR INDUSTRY: State of Washington

11. BIRTHPLACE (State or foreign country): Weippe, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Miles — BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Sarah Derbery — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: N.O.N.E

17. INFORMANT'S OWN SIGNATURE: Cecil Miles — ADDRESS: Weippe, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 5699 Bowel Obstruction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Alcoholism

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8/24, 1969, *to* 8/30, 1969, *that I last saw the deceased alive on* 8/30, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Don Glover 507 (Degree or title) MD
23b. ADDRESS: 939 Bryden, Lewiston Ida
23c. DATE SIGNED: 9/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9/3/69
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 9-5-69
REGISTRAR'S SIGNATURE: Glenna Walzer
25. EMBALMER: WC Merchant
LICENSE NO.: FD 5
FIRM NAME: Merchant Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 15 1969 Bureau of Vital Statistics

State File No. 3882
Local Reg. No. 233
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN: Lewiston
c. LENGTH OF STAY (In this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nez Perce 35
c. CITY OR TOWN: Lewiston
d. STREET ADDRESS (If rural, give location): 1523-7th Ave.

3. NAME OF DECEASED (Type or Print): a. (First) George; b. (Middle) B; c. (Last) Banks

4. DATE OF DEATH (Month) (Day) (Year): August 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married	Feb. 11, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
conservationist 08	Nez Perce County	Rodgers, Arkansas	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George S. Banks			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519 42 2753A	George W. Banks	Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple rib fractures. — 15 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Car accident do		00000	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug. 17. 1969 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Car accident

22. *I hereby certify that I attended the deceased from* Aug 15, 1969, *to* Aug 31, 1969, *that I last saw the deceased alive on* Aug 31, 1969, *and that death occurred at* 7:03 p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John F. Rawls	M.D.	3475 Johns Way Lewiston Idaho	Sept 6 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 3, 1969	Normal Hill cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-8-69	Elenara Walzen	V. Vassar	E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3883
Local Reg. No. 138
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35 SEP 1 51969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
Bureau of Vital Statistics
LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 28

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lapwai
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First) LOYAL
b. (Middle) WILLIAM
c. (Last) RICHARDSON

4. DATE OF DEATH (Month) (Day) (Year) 31 August 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 3 April 1909

9. AGE (In years last birthday) 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance 08

10b. KIND OF BUSINESS OR INDUSTRY State Hi-Way

11. BIRTHPLACE (State or foreign country) Cottonwood, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Earl L. Richardson
BIRTHPLACE Pullman, Wn.

14. MOTHER'S MAIDEN NAME Slyvia June Terwillegar
BIRTHPLACE Colfax, Wn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 09 4157

17. INFORMANT'S OWN SIGNATURE Mrs. Charles Conlee
ADDRESS Lapwai, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardiovascular disease by history
INTERVAL BETWEEN ONSET AND DEATH: expected with warning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____ *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 11:05 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Richard W Thorson MD (Degree or title)

23b. ADDRESS 307 St Johns Way - Lewiston

23c. DATE SIGNED 4 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial

24b. DATE 5 Sept 1969

24c. NAME OF CEMETERY OR CREMATORY Prairie View Cemetery

24d. LOCATION (City, town, or county) (State) Grangeville, Idaho Co., Idaho

DATE REC'D BY LOCAL REG. 9-2-69

REGISTRAR'S SIGNATURE Glenard Dalzen

25. EMBALMER K H Malocm

LICENSE NO. E-376

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3884
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Owyhee 370 SEP 1 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale
c. LENGTH OF STAY (In this place)
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homedale Nursing Home 305

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Marcia	Mae	Schroeder	August 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 20, 1881	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
56		Sauk Center, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Cook	Iowa	Harriett Hader	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-62-0213 T	x Laura C. Douthit	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 1953, to Aug 31, 1969, that I last saw the deceased alive on Aug 27, 1969, and that death occurred at 1 p m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
570 MD		Caldwell	9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 4, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 12 1969	Andrew Mayfield	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3885
Local Reg. No. 140
Reg. Dist. No. 330

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Payette 38C SEP 1 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Casa Loma Convalescent Home 350

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 38C
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 1019 3rd Ave. So.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Alonzo	Edward	Currier	July	25	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Feb. 25, 1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Streeter, Illinois
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME George Currier — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Ida Sikes — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 721-16-6263
17. INFORMANT'S OWN SIGNATURE Lora Adelle Josephson — ADDRESS Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic heart disease — years

DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967, 19___, *to* 7-25-69, 19___, *that I last saw the deceased alive on* 7-5-69, 19___, *and that death occurred at* 2:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 574 — 23b. ADDRESS Payette, Idaho — 23c. DATE SIGNED 7-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-28-69	Riverside Cemetery	Payette, Payette Idaho

DATE REC'D BY LOCAL REG. 9-12-69 — REGISTRAR'S SIGNATURE — 25. EMBALMER Melford O Drages — LICENSE NO. E318

FIRM NAME: Chapel of The Roses

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3886
Local Reg. No. 138
Reg. Dist. No. 330

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette (380)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
LENGTH OF STAY (in this place): 5½ Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center (553)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette (380)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 427 N 9th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	WARREN	RUSSELL	August 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	August 26, 1884	84	-- / --	-- / --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 07	Farming	Monmouth, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frederick Russell	Mass.	Ella Augusta Ray	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	--	518-30-3301 A	E. Alfred Russell	New Plymouth, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1½ days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-11-67, 19__, *to* 8-19-69 19__, *that I last saw the deceased alive on* 8-19-69, 19__, *and that death occurred at* 9:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Payette, Idaho	8-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 22, 1969	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-8-69	[signature]	[signature]	E-517

FIRM NAME: Shaffer-Jensen Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3887
Local Reg. No. 137
Reg. Dist. No. 330

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
c. LENGTH OF STAY (in this place) 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 126 SE Blvd. 380

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location) 126 SE Blvd.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CHARLES	ROBERT	BAKER	August 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	July 30, 1948	21	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
General Laborer 04	Farming	Alabama	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Lee Baker	Alabama	Lela L. Thompson	Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	-- --	434-80-5430	Mrs Bonnie Crane	New Plymouth, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I* ~~attended the deceased from~~ Investigated ~~from~~ ~~to~~ *the deceased* ~~on~~ August 22, 1969, *and that death occurred at* 10:30PM., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hardy Harbeson 583	Coroner	Payette, Idaho	8-30-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-26-1969	Park View Cemetery	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-8-69	Mildred Anderson	Keith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED SEP 10 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3888
Local Reg. No. 139
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 3½ Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 335

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 535
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ontario
d. STREET ADDRESS (If rural, give location): 340 N. W. 5th Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Mary; b. (Middle) Susie; c. (Last) Tague

4. DATE OF DEATH: (Month) (Day) (Year): Aug. 23, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 17, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Marker 01

10b. KIND OF BUSINESS OR INDUSTRY: Own

11. BIRTHPLACE (State or foreign country): Payette, Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Frank Reed
BIRTHPLACE: Unk.

14. MOTHER'S MAIDEN NAME: Hattie Bailey
BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 564-36-7665

17. INFORMANT'S OWN SIGNATURE: Josephine E. Allstrom
ADDRESS: Pasco, Wn

MEDICAL CERTIFICATION

#123

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASHD — yrs.
DUE TO (c): Senility — yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1969, *to* Aug, 1969, *that I last saw the deceased alive on* 8-21-69, 19___, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 574

23b. ADDRESS: Payette, Idaho

23c. DATE SIGNED: 8-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-27-1969

24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

24d. LOCATION (City, town, or county) (State): Ontario, Oregon

DATE REC'D BY LOCAL REG.: 9-8-69

REGISTRAR'S SIGNATURE:

25. EMBALMER: Robert J. Bertelsen

LICENSE NO.: De 222

FIRM NAME: Bertelson-Lienkaemper

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

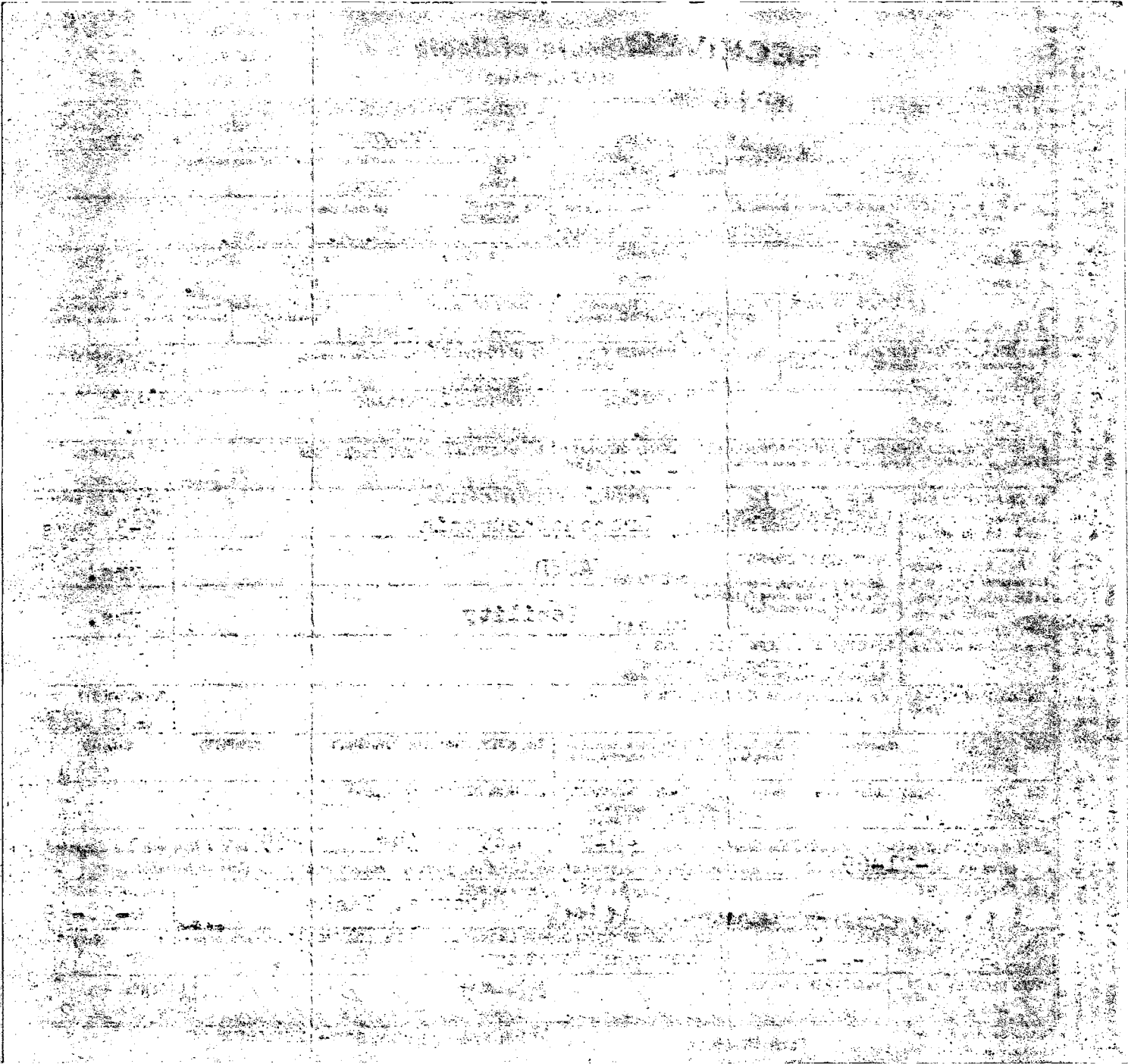

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3889
Local Reg. No. 132
Reg. Dist. No. 330

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
LENGTH OF STAY (in this place): 4 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 618 N 8th

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 618 N 8th

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Frankie	D.	Curtis	Aug.	31	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widow	July 18 1898	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Own Home	Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Eads	Missouri	Jenny Miller	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-26-0010	X William J. Curtis	Ontario, Ore.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial infarction	10 min.
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary Thrombosis	10 min.
DUE TO (c)	Arteriosclerotic Cardiovascular Disease	1 year
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 15, 1969 *to* Aug 31, 1969, *that I last saw the deceased alive on* Aug. 15, 1969, *and that death occurred at* 8:50 pm. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. L. Arnold M.D.	Payette Idaho	9/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial-Removal	9-4-69	Valley View Cemetery	Vale Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-4-69	Arnold Anderson	Donald F Brown	E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3890
Local Reg. No. 3
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED
AUG 19 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Power
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West end of Am. Falls Dam

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 815 West 13th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Joseph	Schafer	August 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Nov. 23, 1901	67	8	11		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer-retired	City of Burley	Ault, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Phillip Schafer,	Germany	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - - -	518-10-0393	William Schafer Jr.	Rt #3 Rupert

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* $\$\$\$

DUTIES:

AUG 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3891
Local Reg. No.
Reg. Dist. No. 600-602

BIRTH NO. RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY Power 390 AUG 19 1969

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burea American Falls

c. LENGTH OF STAY (in this place) 14 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital (37

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho b. COUNTY Power 390

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROSA		HORNBACHER	Aug. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Married	Jan. 30, 1894	75	6	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Odessa, South Russia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Koschel	Russia	Maria Karch	Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-40-4299B	X John Hornbacher	Am. Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4270

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Cent Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-15, 19 68, *to* Aug 10, 19 69 *that I last saw the deceased alive on* Aug 10, 19 69 *and that death occurred at* 4:20 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
255 I. A. Hunt MD	American Falls Ida	7-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-13-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 18, 1969	Irene Deeg	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 2 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-6266
BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 3892
Local Reg. No. 5
Reg. Dist. No. 500-602

RECEIVED
AUG 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Power 390

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls

c. LENGTH OF STAY (in this place): Few min.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Power 390

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, American Falls

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRANK	M.	SANCHEZ	Aug. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Mexican	Infant	June 15, 1969	0	1	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		American Falls	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Donato Sanchez	Texas	Aney Martinez	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		None	Donato Sanchez	Am. Falls, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4867

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-13, 1969, *to* 8-13, 1969, *that I last saw the deceased alive on* 8-13, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. A. Hunt 255	MD	American Falls Ida	8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-15-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 20, 1969	Irene Deeg	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3893
Local Reg. No. 7
Reg. Dist. No. 500-602

RECEIVED
AUG 28 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Power 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place): 2 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 37

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: Box Elder 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Plymouth, Rural
d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print): a. (First) Marvilla b. (Middle) c. (Last) Pierson

4. DATE OF DEATH (Month) (Day) (Year): Aug. 17th 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Feb. 5th 1895

9. AGE (In years last birthday): 74 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaking 81

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Plymouth, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hemon W. Pierson
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Janet Archibald
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: xLucetta Turner
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1560

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malnutrition from Metastatic adeno- — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) carcinoma of gall bladder and multiple pulmonary infarction — 2 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerosis (generalized) — 8 years

19a. DATE OF OPERATION: 8-7-69

19b. MAJOR FINDINGS OF OPERATION: Chronic cholecystitis and cholelithiasis and adenocarcinoma GB. Metastasis alongportal system.

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-1-69, 19—, *to* 8-17-69, 19—, *that I last saw the deceased alive on* 8-17-69, 19—, *and that death occurred at* 7:10 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: J L Harris 303 (Degree or title) M.D.

23b. ADDRESS: 213 Idaho Street, American Falls, Idaho

23c. DATE SIGNED: 8-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem.& Burial

24b. DATE: 8/20/69

24c. NAME OF CEMETERY OR CREMATORY: Plymouth

24d. LOCATION (City, town, or county) (State): Plymouth, Utah

DATE REC'D BY LOCAL REG.: Aug. 27, 1969

REGISTRAR'S SIGNATURE: Irene Deeg

25. EMBALMER: G. Ward Taylor

LICENSE NO.: 446

FIRM NAME: Rogers Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3894
Local Reg. No. 6
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 508 Roosevelt

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location) 508 Roosevelt

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	PAUL	WILLIAMS	Aug. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Unknown	Oct. 14, 1900	68	10	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender 23	Bar	Hopkinsville, Kentucky	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW2	519-09-8558A	x Margery Mackie	Am. Falls, Ida.

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage & occlusion, anterior coronary artery

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocardial infarction, heart early

DUE TO (c) Atherosclerosis & arteriosclerosis; arteries, severe

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on* 8-17, 19 69, *and that death occurred at* 2:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bud Kelly 583 Coroner	American Falls, Idaho	8-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-20-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 22, 1969	Irene Deeg	H. L. Davis	E-253

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

DUTIES:

AUG 28 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3895
Local Reg. No. 160
Reg. Dist. No. 140

BIRTH NO.

RECEIVED AUG 13 1969

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton Rur 2
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 10-Near Silverton

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joseph	Thomas	Richardson Jr.	Aug. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Aug. 21, 1953	15				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 33
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oak Park, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Thomas Richardson — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Julianne Kramer — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 532-56-4564
17. INFORMANT'S OWN SIGNATURE: X J. Richardson — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Neck & 8129
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Basal Skull Fractures
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Few seconds

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway near Silverton Bridge
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Silverton, Shoshone, 402 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8-5-69 about 7:35 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? automobile-truck Collision

22. *I hereby certify that I attended the deceased from* 8-5- 1969, *to* 8-5- 1969, *that I last saw the deceased alive on* 8-5- 1969, *and that death occurred at* about 7:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: G. M. Peterson, M.D. (Degree or title): M.D.
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 8-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 8-1969
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: Aug 8-1969
REGISTRAR'S SIGNATURE: Dan Kramer
25. EMBALMER: Dale L. Cornell
LICENSE NO.: E-406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3896
Local Reg. No. 59
Reg. Dist. No. 142

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
AUG 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 401
a. COUNTY Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 612 Chestnut Street

3. NAME OF DECEASED (Type or Print) a. (First) Julia b. (Middle) M. c. (Last) Lightner

4. DATE OF DEATH (Month) (Day) (Year) Aug. 8, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan 19, 1897
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Boulder, Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Miller — BIRTHPLACE California
14. MOTHER'S MAIDEN NAME Julia Wade — BIRTHPLACE Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. ---
17. INFORMANT'S OWN SIGNATURE X [signature] — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH 48 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Coronary artery Disease — 8 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Essential Hypertension — 30 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Kellogg (COUNTY) Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1949 *to* 8 Aug, 1969 *that I last saw the deceased alive on* 8 Aug, 1969, *and that death occurred at* 9:17 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 534 [signature] M.D.
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 13 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 11, 1969
24c. NAME OF CEMETERY OR CREMATORY Fairmount Mem. Park
24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. 8-18-69
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Russell D. Mikel
LICENSE NO. E 520

FIRM NAME: Cornell's Maisel Funeral C.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3897 60
Local Reg. No.
Reg. Dist. No. 147

BIRTH NO.

RECEIVED AUG 22 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 40
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg R.
c. LENGTH OF STAY (in this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. W. Shoshone Gen. 41

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 40
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 817 Park Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Maud	A.	Blackman	Aug. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	July 5, 1880	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 0	Home	Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Nc Nary		Jane Swallum	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No None	518-01-7624	* Mrs Blythe Hersey	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4419 Ruptured Aneurysm of Aorta — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-9- 1969, *to* 8-9-, 1969, *that I last saw the deceased alive on* 8-9, 1969, *and that death occurred at* about 10:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. M. Peterson 414, M.D.	Wallace, Idaho	8-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/13/1969	Forest Lawn	Coeur D' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-20-69	Joe Petrone	Alan A. Peterson	E 534

FIRM NAME: Cornell's Waisel Fun'l Chap

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3898
Local Reg. No. 698
Reg. Dist. No. 147

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 22 1969 Bureau of

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst
d. STREET ADDRESS (If rural, give location): 305 South Sixth

3. NAME OF DECEASED (Type or Print): a. (First) GLENN b. (Middle) HOMER c. (Last) MATLOCK

4. DATE OF DEATH (Month) (Day) (Year): August 10, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Nov. 23, 1907

9. AGE (In years last birthday): 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Kamiah, Idaho

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME — BIRTHPLACE: Claude P. Matlock, Tennessee

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Olena Christine Asplund, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No ---

16. SOCIAL SECURITY NO.: 1540

17. INFORMANT'S OWN SIGNATURE — ADDRESS: X Mary H. Matlock Pinehurst, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic carcinoma, rectosigmoid colon — INTERVAL BETWEEN ONSET AND DEATH: 9 months or longer

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 Nov, 1968, *to* 10 Aug, 1969, *that I last saw the deceased alive on* 10 Aug, 1969, *and that death occurred at* 12:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert R. Cordwell, M.D. 105

23b. ADDRESS: Kellogg, Idaho

23c. DATE SIGNED: 13 Aug 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Aug. 13, 1969

24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 8-18-69

REGISTRAR'S SIGNATURE: Joe Keene

25. EMBALMER: Dean D. Peterson

LICENSE NO.: E-534

FIRM NAME: Cornell's Maisel Funeral Chap

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept 16, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3899
Local Reg. No. 63
Reg. Dist. No. 142

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Shoshone 402	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton c. LENGTH OF STAY (In this place): Months	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shoshone Co. Nursing Home 344	d. STREET ADDRESS (If rural, give location): 212 Main Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Walter	James	Owen	August	12,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Jan 25, 1879	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner-Operator 22	Sporting Goods	Towanda, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable		Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-54-0920	Mrs. John E. Herrett	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

794X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Old age and general debility	about 2 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12 Feb, 19 51, *to* 12 Aug, 19 69, *that I last saw the deceased alive on* 11 Aug, 19 69, *and that death occurred at* 6:30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert W. Cordwell, M.D. 105	Kellogg, Idaho	20 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 15, 1969	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-69	Joe Irvine	Dean ~~Patersen~~	E 534

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Maisel Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
SEP 16 1969
Bureau of Vital Statistics

State of Idaho } ss.
County of Shoshone

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Walter J. Owens (Name on Original Certificate) who died (Was Born or Died) on August 12, 1969 (Date of Event)
in Silverton, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name of Deceased	Walter J. Owens	Walter James Owen
Place of Birth #11	Lowoudox, Kansas	Towanda, Kansas

Subscribed and sworn to before me this 15th day of October ~~September~~ 19 69.

Notary Public, residing at Kellogg, Idaho
My commission expires 5-1-74
(Seal)

Signed (Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

106 S. Main St., Kellogg, Idaho (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Shoshone

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 15th day of September 19 69.

Notary Public, residing at Kellogg, Idaho
My commission expires 5-1-74
(Seal)

Signed (Signature of Any Credible Person)

Hutton Bldg., Kellogg, Idaho (Street Address, City, State)

FORM DH 60-155

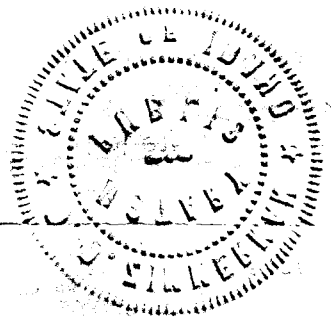

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No.
Local Reg. No. 63
Reg. Dist. No. 142

BIRTH NO.

SEP 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (in this place): Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shoshone Co. Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 212 Main Street

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): J.
c. (Last): Owens

4. DATE OF DEATH (Month) (Day) (Year): Aug. 12, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 25, 1879
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner-Operator
10b. KIND OF BUSINESS OR INDUSTRY: Sporting Goods
11. BIRTHPLACE (State or foreign country): Lowoudox, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME / BIRTHPLACE: Unobtainable
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-54-0920
17. INFORMANT'S OWN SIGNATURE / ADDRESS: x Mrs. John E. Herrett

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Old age and general debility — INTERVAL BETWEEN ONSET AND DEATH: above 2 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 Feb, 1951, *to* 12 Aug, 1969, *that I last saw the deceased alive on* 11 Aug, 1969, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert W. Cordwell, MD
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 20 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 15, 69
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 8-28-69
REGISTRAR'S SIGNATURE: Joe Irvine
25. EMBALMER: Dean R. Petersen
LICENSE NO.: E 534

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3900
Local Reg. No. 62
Reg. Dist. No. 140

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
AUG 26 1969
Bureau of Vital Statistics
b. CITY OR TOWN: Silverton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burke
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Rudolph b. (Middle) Henry c. (Last) Sprute

4. DATE OF DEATH: (Month) August (Day) 15 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: December 24, 1905

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist 07

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Keuterville, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Kasper Sprute
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Clara Dasenbrock
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-03-1633

17. INFORMANT'S OWN SIGNATURE: Mark R. Sprute
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion 4109
INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-15 1969 *to* 8-15, 1969, *that I last saw the deceased alive on* 8-15, 1969, *and that death occurred at* about 1 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. M. Peterson 414 (Degree or title): M.D.
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 8-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Cottonwood
24d. LOCATION (City, town, or county) (State): Cottonwood Idaho

DATE REC'D BY LOCAL REG.: 8-21-69
REGISTRAR'S SIGNATURE: Dale L. Cornell

25. EMBALMER: Derrell J. Juelfs
LICENSE NO.: E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3901
Local Reg. No. 62
Reg. Dist. No. 142

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 40
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF (If not in this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp. 41

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Enaville
d. STREET ADDRESS (If rural, give location): Box 24 Rural Enaville

3. NAME OF DECEASED (Type or Print)
a. (First): Egil
b. (Middle): Vardemar
c. (Last): Rathje

4. DATE OF DEATH (Month) (Day) (Year): Aug. 19, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Febr. 20, 1902
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Stavanger, Norway
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Unobtainable
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 516-10-3002
17. INFORMANT'S OWN SIGNATURE — ADDRESS: x Josie Bates

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart Disease & Emphasis — Several months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Curtailing of Liver & Ascites — ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg Shoshone Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 17 Aug, 1969 *to* 19 Aug, 1969, *that I last saw the deceased alive on* 19 Aug, 1969, *and that death occurred at* 1:22 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Glen M. Whiteneck 539 M.D.
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 20 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/22/69
24c. NAME OF CEMETERY OR CREMATORY: Red Lodge Cemetery
24d. LOCATION (City, town, or county) (State): Red Lodge, Montana

DATE REC'D BY LOCAL REG.: 8-28-69
REGISTRAR'S SIGNATURE: Joe Stone
25. EMBALMER: Dean H. Petersen
LICENSE NO.: E 534

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Maisel Funeral Chap.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3902
Local Reg. No. 6
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 450 — SEP 4 1969 — Bureau of Vital Statistics
b. CITY OR TOWN Big Creek, Idaho — c. LENGTH OF STAY IN THIS PLACE Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION Sunshine Mine 900

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Kootenai 250
c. CITY OR TOWN Cataldo
d. STREET ADDRESS (If rural, give location) Rural Cataldo

3. NAME OF DECEASED (Type or Print) — a. (First) Robert — b. (Middle) Edward — c. (Last) Finlay

4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 13, 1919

9. AGE (In years last birthday) 50 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner 57

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Paradise, Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry A. Finley — BIRTHPLACE Ohio

14. MOTHER'S MAIDEN NAME Emma Gray — BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W.W.II 4

16. SOCIAL SECURITY NO. 553-18-9701

17. INFORMANT'S OWN SIGNATURE Mrs. Robert Finlay — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Contusions + abrasions of entire body
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Left Leg amputated at knee Internal Injuries Crushed Chest
DUE TO (c) Fractured Neck, Multiple Compound fractures of skull, severe laceration of right mid abdomen + evisceration of small intestine, penetrating wounds of right face, compound comminuted fracture of right humerus + radius

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1 second

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) In Sunshine Mine

21c. (CITY, TOWN, OR TOWNSHIP) near Kellogg (COUNTY) Shoshone 400 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-20-69 about 7:50 P.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Struck by fine ore while working in sinking compartment of shaft

22. *I hereby certify that I attended the deceased from* 8-20, 1969, *to* 8-20, 1969, *that I last saw the deceased alive on* 8-20, 1969, *and that death occurred at* 7:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) T. M. Peterson, M. D.

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED 8-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/23/69

24c. NAME OF CEMETERY OR CREMATORY Shoshone Mem. Gardens

24d. LOCATION (City, town, or county) (State) Pinehurst, Idaho

DATE REC'D BY LOCAL REG. 8/29/69

REGISTRAR'S SIGNATURE Joe Durand

25. EMBALMER Thomas A. Peterson — LICENSE NO. E 534

FIRM NAME Cornell Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 31 2014

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3903
Local Reg. No. 169
Reg. Dist. No. 140

BIRTH NO.

SEP 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WAllace,
d. STREET ADDRESS (If rural, give location) Nine Mile Rd.

3. NAME OF DECEASED (Type or Print)
a. (First) Katherine
b. (Middle) Marie
c. (Last) Thompson

4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb. 15, 1906
9. AGE (In years last birthday) 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Burke, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-01-6121
17. INFORMANT'S OWN SIGNATURE Mrs. Nona Fousett — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-6-57, *19*___, *to* 8-20-69, *19*___, *that I last saw the deceased alive on* 8-20-69, *19*___, *and that death occurred at* 8:20p *m., from the causes and on the date stated above.*

23a. SIGNATURE E. E. Gnaedinger 182 (Degree or title) MD
23b. ADDRESS Box 200 Wallace, Idaho
23c. DATE SIGNED 8-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-25-69
24c. NAME OF CEMETERY OR CREMATORY Nine Mile Cemetery
24d. LOCATION (City, town, or county) (State) Wallace, Idaho

DATE REC'D BY LOCAL REG. Aug 27-69
REGISTRAR'S SIGNATURE Dale J. Cornell
25. EMBALMER Derrell J. Juelfs
LICENSE NO. E-518

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

DUTIES: SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3904
Local Reg. No. 144
Reg. Dist. No. 140

Certificate of Death

RECEIVED
SEP 2 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Dale
b. (Middle): E.
c. (Last): Beck

4. DATE OF DEATH (Month) (Day) (Year): Aug. 21, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 23, 1931
9. AGE (In years last birthday): 38 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contract Miner 67
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): Lead, South Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Beloit Beck — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Evelyn Boyer — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1952-1954 6
16. SOCIAL SECURITY NO.: 518-24-2308
17. INFORMANT'S OWN SIGNATURE: X Mrs. Dale Beck — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

887X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Internal injuries — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Multiple Fractures & Contusions — Minutes

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hecla Mining Co
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Wallace 400 Shoshone Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Fall in underground Shaft

22. *I hereby certify that I attended the deceased from* 9-17-58, 19__, *to* 8-21-69, 19__, *that I last saw the deceased alive on* 5-24-69, 19__, *and that death occurred at* 1:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. E. Gnaedinger MD 182
23b. ADDRESS: Box 200 Wallace, Idaho
23c. DATE SIGNED: 8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: St. Thomas Cemetery
24d. LOCATION (City, town, or county) (State): Coeur D Alene Idaho

DATE REC'D BY LOCAL REG.: 8-28-69
REGISTRAR'S SIGNATURE: Dale J. Cornell
25. EMBALMER: Derrell J. Juelfs
LICENSE NO.: E-518

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 15 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3905
Local Reg. No. 103
Reg. Dist. No. 140

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 40 — AUG 26 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East Shoshone Hospital 138

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 40
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mullan
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	J.	Kambeitz	August 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct. 8, 1900	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shaft Repairmen 22	Mining	Bismark, North Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Kambeitz	Unknown	Magdalena Buggonmeier	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	516-12-1028A	X William A. Erickson	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular failure — INTERVAL BETWEEN ONSET AND DEATH: unknow

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cachexia — 18 months
DUE TO (c) Bronchiogenic Carcinoma — over 2 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* severe anemia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-29 *, 19*69 *to* 21 Aug *, 19*69*, that I last saw the deceased alive on* 20 Aug *, 19*69 *and that death occurred at* 8:05 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William K Lee M.D.		Wallace	21 Aug. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-23-69	Mullan Cemetery	Mullan, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 21-1969	Dale Harnell	Dale L. Cornell	E-406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 2 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 5 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3906
Local Reg. No. 66
Reg. Dist. No. 143

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 1 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): Vet's Housing

3. NAME OF DECEASED (Type or Print)
a. (First): JOAN
b. (Middle): ORA
c. (Last): KING

4. DATE OF DEATH (Month) (Day) (Year): Aug. 30, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 4, 1939
9. AGE (In years last birthday): 30 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oral Kessinger — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Mary Mc kibben — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-44-0563
17. INFORMANT'S OWN SIGNATURE: x Oral Kessinger — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3919

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute rheumatic carditis c̄ failure — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/24, 1969, *to* 8/30, 1969, *that I last saw the deceased alive on* 8/30/69, 19__, *and that death occurred at* 8:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Keith Dahlberg 811 (Degree or title): MD
23b. ADDRESS: 204 Oregon St. Kellogg
23c. DATE SIGNED: 8/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/3/1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Mem. Grdns.
24d. LOCATION (City, town, or county) (State): Pinehurst, Idaho

DATE REC'D BY LOCAL REG.: 9-18-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Dean H Petersen — LICENSE NO.: E 534

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Maisel Fun'l Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-8518
BIRTH NO.

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3907
Local Reg. No.
Reg. Dist. No. 620

1. PLACE OF DEATH
a. COUNTY: Teton 10 — SEP 18 1969
b. CITY OR TOWN: Driggs — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton County Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Texas 44
b. COUNTY: Unknown 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Donna
d. STREET ADDRESS (If rural, give location): none given

3. NAME OF DECEASED (Type or Print)
a. (First): Guadalupe
b. (Middle):
c. (Last): Lerma

4. DATE OF DEATH: (Month) (Day) (Year): Aug 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	spanish	child	Aug 18, 1969	1 day		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child 07
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Driggs, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Emanuel Lerma — BIRTHPLACE: Mexido
14. MOTHER'S MAIDEN NAME: Manuela Aguilar — BIRTHPLACE: Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Family records — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7729

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Birth Injuries — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature Baby

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-18, 1969, *to* 8-19, 1969, *that I last saw the deceased alive on* 8-19, 1969, *and that death occurred at* 5:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K Head MD
23b. ADDRESS: Driggs Idaho
23c. DATE SIGNED: 9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Driggs Cemetery
24d. LOCATION (City, town, or county) (State): Driggs, Idaho

DATE REC'D BY LOCAL REG.: 9-18-69
REGISTRAR'S SIGNATURE: Ella Driggs
25. EMBALMER: Robert Bean — Robert Bean — LICENSE NO.: E-456
FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3908
Local Reg. No. D-274
Reg. Dist. No. 460

Certificate of Death

RECEIVED
AUG 26 1969
Bureau of Vital Stat.

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Murtaugh
c. LENGTH OF STAY (in this place): 47 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Murtaugh 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Murtaugh
d. STREET ADDRESS (If rural, give location): Murtaugh

3. NAME OF DECEASED (Type or Print)
a. (First): Richard
b. (Middle): Rex
c. (Last): Craner

4. DATE OF DEATH (Month) (Day) (Year): July 16, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: May 29, 1922
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Disabled 28
10b. KIND OF BUSINESS OR INDUSTRY: Disabled
11. BIRTHPLACE (State or foreign country): Churchill, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Arleth Craner — BIRTHPLACE: Oakley, Idaho
14. MOTHER'S MAIDEN NAME: Gladys Lee — BIRTHPLACE: Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. 2 4
16. SOCIAL SECURITY NO.: 519-18-0301
17. INFORMANT'S OWN SIGNATURE: Tamera LaDean Brown — ADDRESS: Burley, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease with left heart failure — 5 yrs.
DUE TO (c) Cerebral thrombosis with stroke right hemiplegia — 3 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes mellitus — 25 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug., 1956, *to* July, 1969, *that I last saw the deceased alive on* July 15, 1968, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O. Ellis Knight MD 286
23b. ADDRESS: Kimberly, Idaho.
23c. DATE SIGNED: 8-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7/16/69
24c. NAME OF CEMETERY OR CREMATORY: Oakley Cemetery
24d. LOCATION (City, town, or county) (State): Oakley, Idaho

DATE REC'D BY LOCAL REG.: August 22, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Jerry K. Lawson — LICENSE NO.: E-522

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary-Burley

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3909
Local Reg. No. D-257
Reg. Dist. No. 460

BIRTH NO. 69-7483

RECEIVED AUG 12 1969 Bureau

1. PLACE OF DEATH
a. COUNTY: Twin Falls 43
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Nevada 29
b. COUNTY: Elko 535
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elko
d. STREET ADDRESS (If rural, give location): 613 1/2 Cedar Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DONALD	LEE	WIGGINS WIDNER	8 - 1 - 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never married	7 - 29 - 1969		3	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant 02		Twin Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Donald W. Wiggins	Elko, Nevada	Arlene Jarvis	Lewiston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Arlene E. Widner	Elko, Nevada

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

7769

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 3 dy

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Prematurity — 3 dy
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Respiratory Distress Syndrome

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7/29, 1969 *to* 8/1, 1969, *that I last saw the deceased alive on* 8/1/69, 19____, *and that death occurred at* 11:25a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ben Stat 274 M.D.	676 Shoup Ave. W. Twin Falls, Idaho	8/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8 - 4 - 1969	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-8-69	Vera Ryals	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3910
Local Reg. No. D-253
Reg. Dist. No. 460

RECEIVED AUG 8 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
LENGTH OF STAY (in this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 661 3rd Ave. West 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 661 3rd Ave. West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	EVERETT	PENNOCK	August 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	April 22, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired (Laboratory)	Sugar Company 21	Boulder, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James M. Pennock	Seymour, Indiana	Fannie M. Young	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-07-9076	Idaho Falls Idaho	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute pulmonary edema	1 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Congestive heart failure	?
DUE TO (c)	Hypertension and arteriosclerosis	15 yrs

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* 8/2, 1969, *and that death occurred at* 4:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 476	MD	Twin Falls, Idaho	8/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 5, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-6-69	Vera Ryals	Jerry D. Holman	E-516

FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 24 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3911
Local Reg. No. D-252
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls — AUG 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazeldel Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls, 83301
d. STREET ADDRESS (If rural, give location): 640 Filer Ave. West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NELLIE	WILSON	GRIGGS	August 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	August 25, 1878	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Wilson	Indiana	Amanda Wieg	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-44-7549	x D B Griggs	Twin Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease many years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5-29-, 1969, to Aug 3, 1969, that I last saw the deceased alive on Aug 3, 1969, and that death occurred at 3:10 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George W Warner MD	111 6th Ave E Twin Falls	8/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	August 7, 1969	Mt. View Crematory	Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-6-69	Vera Ryals	Jerry D. Holman	E-516

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3912
Local Reg. No. D-254
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 — AUG 8 1969
b. CITY OR TOWN: Twin Falls — Bureau of Vital Statistics
c. LENGTH OF: hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1610 Kimberly Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Nebraska 28
b. COUNTY: Saunders 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashland 68003
d. STREET ADDRESS (If rural, give location): 1302 Boyd

3. NAME OF DECEASED (Type or Print)
a. (First): KATHERINE
b. (Middle): SARAH
c. (Last): LOHR

4. DATE OF DEATH (Month) (Day) (Year): Aug. 4, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: March 19, 1894
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edwin P. Knode — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Eva Granger — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - - - -
16. SOCIAL SECURITY NO.: 506-56-3787
17. INFORMANT'S OWN SIGNATURE ADDRESS: Ashland, Nebr.
x Neva Wolkow

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DID NOT ATTEND, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Twin Falls County (Degree or title) Coroner — Cloyce O. Edwards 583 4
23b. ADDRESS: Route 3, Twin Falls, Idaho
23c. DATE SIGNED: Aug. 6, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 8-6-69
24c. NAME OF CEMETERY OR CREMATORY: Ashland Cemetery
24d. LOCATION (City, town, or county) (State): Ashland, Nebraska

DATE REC'D BY LOCAL REG.: 8-6-69
REGISTRAR'S SIGNATURE: Vera Ryals
25. EMBALMER: William J. Boyd
LICENSE NO.: E-490

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: TWIN FALLS MORTUARY

DUTIES:

AUG 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3913
Local Reg. No. D-258
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH a. COUNTY: Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho 13 b. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls R c. LENGTH OF STAY (In this place): 9 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Skyview Manor Nursing Home 273	d. STREET ADDRESS (If rural, give location): 640 Filer Ave. West

3. NAME OF DECEASED (Type or Print) a. (First): HERMA	b. (Middle): HALL	c. (Last): DAVIS	4. DATE OF DEATH (Month) (Day) (Year): Aug. 6, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Dec. 22, 1878	9. AGE (In years last birthday): 90 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Nebraska City, Nebraska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: H.O. Hall	BIRTHPLACE: unknown	14. MOTHER'S MAIDEN NAME: Celia	BIRTHPLACE: unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-62-2461	17. INFORMANT'S OWN SIGNATURE: Gerald H Metzger	ADDRESS: Idaho Falls, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Sclerosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Old Age Gen Arteriosclerosis

DUE TO (c) Gen debility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1960, *to* Aug 6, 1969, *that I last saw the deceased alive on* Aug 1, 1969, *and that death occurred at* 1:40p *m., from the causes and on the date stated above.*

23a. SIGNATURE: Dr G Drake MD (Degree or title)	23b. ADDRESS: 594 Hazelwood Dim	23c. DATE SIGNED: 8-7-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: Aug. 8, 1969	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State): Syracuse, Nebraska
DATE REC'D BY LOCAL REG.: 8-8-69	REGISTRAR'S SIGNATURE: Vera Ryals	25. EMBALMER: Ronald J. Hamilton	LICENSE NO.: E-470

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3914
Local Reg. No. D-262
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 15 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls (421)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: T. Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
d. STREET ADDRESS (If rural, give location): 326 South Chestnut Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WALTER		HAGER	August 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 28, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Farmer of		Anthony, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John F. Hager	Mecklenburg, Germany	Lydia E. Haley	Sweet Springs, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. #1 3	519-05-0715 A	x Mrs. Walter Hager	Kimberly, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) — 2050

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute leukemia, myeloblastic	3 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	1. Pulmonary emphysema 2. Chronic bronchitis	10 yr + 10 yr +

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-7-69, 19___, *to* 8/6/, 19 69, *that I last saw the deceased alive on* 8-5, 19 69, *and that death occurred at* 6:40a. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James H. Gifford M.D.	Twin Falls, Idaho	8/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/9/69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/13/69	Vera Ryals	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3915
Local Reg. No. D-363
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 027
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: T.Falls 027
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 1429 Poplar Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MAURICE	L.	MELTON	August 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 15, 1908	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Store Clerk 25		Conway Springs, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Melton	Missouri	Mary Troxell	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-09-7730	Twin Falls, Brenda M. Melton	Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Carcinoma Lung - 1621	4 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-, 1969, *to* 8/6/, 1969, *that I last saw the deceased alive on* 8-6, 19 69 *and that death occurred at* 4:20p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Brumbach	M.D.	Twin Falls, Idaho	8/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/9/69	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/13/69	Vera Ryals	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3916
Local Reg. No. D-275
Reg. Dist. No. 460

BIRTH NO AUG 2 6 1969

1. PLACE OF DEATH
a. COUNTY Bureau of Vital Statistics Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 11 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 312 13th Avenue North

3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) c. (Last) VAN ZANTE

4. DATE OF DEATH (Month) (Day) (Year) Aug. 6, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH March 21, 1875

9. AGE (In years last birthday) 94
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Friesland, Netherlands

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wilburn Terpstra BIRTHPLACE Netherlands

14. MOTHER'S MAIDEN NAME Anna Vermeer BIRTHPLACE Netherlands

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE R. J. Van Zante RFD #4 ADDRESS Buhl, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Heart Failure Due to

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b) Arteriosclerotic Heart Disease Due to

DUE TO (c) Gen. Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Senility

INTERVAL BETWEEN ONSET AND DEATH
(a) about 1 year
(b) 10-15 yrs.
(c)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW, DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-17-68, 19 to Aug 6, 1969, *that I last saw the deceased alive on* Aug 2, 1969, *and that death occurred at* 10:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Wm H Anderson MD (Degree or title)

23b. ADDRESS Buhl, Idaho

23c. DATE SIGNED 8-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/11/69

24c. NAME OF CEMETERY OR CREMATORY Filer I.O.O.F.

24d. LOCATION (City, town, or county) Filer, (State) Idaho

DATE REC'D BY LOCAL REG. August 20, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER George Tanner LICENSE NO. E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3917
Local Reg. No. D-259
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 12 1969

1. PLACE OF DEATH
a. COUNTY Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Colorado 06 b. COUNTY Morgan 535
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Morgan
d. STREET ADDRESS (If rural, give location) 518 Main Street

3. NAME OF DECEASED (Type or Print) a. (First) JOSE b. (Middle) CANUTO c. (Last) HERRERA

4. DATE OF DEATH (Month) (Day) (Year) August 7, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept. 23, 1933

9. AGE (In years last birthday) 35
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Las Vegas, New Mexico

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John J. Herrera
BIRTHPLACE New Mexico

14. MOTHER'S MAIDEN NAME Aurelia Lucero
BIRTHPLACE New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) - - - - - -

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT'S OWN SIGNATURE Dorotea M Herrera, ADDRESS Ft. Morgan, Colo.

8199

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Renal Failure (Renal Shut down) and pulmonary edema

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Surgical shock

DUE TO (c) Multiple fracture of ribs and pelvis and cerebral concussion

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Twin Falls Twin Falls 424 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8/3/69 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Automobile Accident

22. *I hereby certify that I attended the deceased from* 8/3/ *, 19* 69 *to* 8/7/ *, 19*69*, that I last saw the deceased alive on* 8/7/69 *, 19* ___ *, and that death occurred at* 1:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE Vaughn McDonald M.D. (Degree or title)

23b. ADDRESS 1216 Filer Ave. East T.F. Ida

23c. DATE SIGNED Aug. 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Aug. 9, 1969

24c. NAME OF CEMETERY OR CREMATORY Frezieres Funeral Hme.

24d. LOCATION (City, town, or county) (State) Brush, Colorado

25. EMBALMER William J Boyd

LICENSE NO. E-490

DATE REC'D BY LOCAL REG. 8-8-69

REGISTRAR'S SIGNATURE Vera Ryals

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED AUG 15 1969

State File No. 3918
Local Reg. No. D-266
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho 13 b. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hospital 144	d. STREET ADDRESS (If rural, give location): 1062 2nd Ave. West

3. NAME OF DECEASED (Type or Print) a. (First): VIRGINIA	b. (Middle): C.	c. (Last): NELSON	4. DATE OF DEATH (Month) (Day) (Year): August 7, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: Nov. 1, 1876	9. AGE (In years last birthday): 92 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Virginia City, Nevada	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-18-2875A	17. INFORMANT'S OWN SIGNATURE: X Donald Dilts	ADDRESS: Same as above	

18. CAUSE OF DEATH 4100
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary occlusion	Minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertensive Cardiovascular disease	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Squamous cell Carcinoma Vagina	4 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-15-, 1969, *to* 8/7, 1969, *that I last saw the deceased alive on* 8/7/, 1969, *and that death occurred at* 5:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE: George W. Warner 551 (Degree or title)	23b. ADDRESS: 111 6th Ave E Twin Falls	23c. DATE SIGNED: 8/8/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 8/11/69	24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery	24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho
DATE REC'D BY LOCAL REG.: 8/13/69	REGISTRAR'S SIGNATURE: Vera Ryals	25. EMBALMER: Donald J. Hamilton	LICENSE NO.: E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3919
Local Reg. No. D-264
Reg. Dist. No. 460

RECEIVED AUG 15 1969

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazel-Del Manor Nursing Home 285	d. STREET ADDRESS (If rural, give location) 203 4th St. No.

3. NAME OF DECEASED (Type or Print)	a. (First) ANNETTE	b. (Middle) MAUD	c. (Last) FRANTZ	4. DATE OF DEATH (Month) (Day) (Year) August 8, 1969
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH May 21, 1889	9. AGE (In years last birthday) 80 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12	10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) Nebraska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Milton Frantz	BIRTHPLACE Indiana	14. MOTHER'S MAIDEN NAME Mary Elizabeth Bronson	BIRTHPLACE Ohio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 503-36-5684A	17. INFORMANT'S OWN SIGNATURE x Walter W Miller	ADDRESS Twin Falls, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Stroke (C.V.A.) — INTERVAL BETWEEN ONSET AND DEATH 18 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic cardio-vascular disease — 20 yrs

DUE TO (c) Parkinson Syndrome — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1965 *to* Aug 8, 1969, *that I last saw the deceased alive on* June 8, 1965 *and that death occurred at* 6:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 400 (Degree or title)	23b. ADDRESS Twin Falls Ida	23c. DATE SIGNED 8-11-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE Aug. 11, 1969	24c. NAME OF CEMETERY OR CREMATORY Roseland Cemetery	24d. LOCATION (City, town, or county) (State) Roseland, Nebraska
DATE REC'D BY LOCAL REG. 8/13/69	REGISTRAR'S SIGNATURE Vera Ryals	25. EMBALMER Edgar J Robertson	LICENSE NO. E-507

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 9 1969

NOV 1 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3920
Local Reg. No. D-329
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 15 1969

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: T. Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
d. STREET ADDRESS (If rural, give location): Box 581 Kimberly

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
TERECINA		MARTINEZ	August 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Mexican	Widowed	March 19, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 0		Taos, New Mexico	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	525-58-6885D	X Joe Martinez	Kimberly, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bilateral Peritonitis 5749	4 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	2nd to common duct stone + obstruction	"
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-6, 19 69 *to* 8/8/, 19 69, *that I last saw the deceased alive on* 8-8, 19 69 *and that death occurred at* 12:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Brumbach. OLD M.D.	Twin Falls, Idaho	8/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/11/69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-13-69	Vera Ryals	Earl D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3921
Local Reg. No. D-267
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 15 1969

1. PLACE OF DEATH
a. COUNTY: Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Alabama
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clanton 35045
d. STREET ADDRESS (If rural, give location): 510 9th St. North

3. NAME OF DECEASED (Type or Print)
a. (First): DONIA
b. (Middle):
c. (Last): DeLOACH

4. DATE OF DEATH (Month) (Day) (Year): August 10, 1969

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 25, 1903

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 66

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Jemison, Alabama

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: GREEN
BIRTHPLACE: UNK

14. MOTHER'S MAIDEN NAME: Glascock
BIRTHPLACE: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 422-76-7969

17. INFORMANT'S OWN SIGNATURE: X Charles D. DeLoach
ADDRESS: Travis, Californ

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Basal artery Clot - Cerebrum
INTERVAL BETWEEN ONSET AND DEATH: 24 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypercoagulability
DUE TO (c): Unknown Cause

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES XX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-6, 1969 *to* 8-10, 1969; *that I last saw the deceased alive on* 8-10, 1969, *and that death occurred at* 4:05P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H B Trumbach MD
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 8.12.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: August 13, 1969
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Clanton, Alabama

DATE REC'D BY LOCAL REG.: 8/13/69
REGISTRAR'S SIGNATURE: Vera Ryals
25. EMBALMER: Edgar J. Robertson
LICENSE NO.: E-507
FIRM NAME: WHITE MORTUARY Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 06 2003

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED AUG 15 1969

State File No. 3922
Local Reg. No. D-267
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 450 2nd Ave South

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 450 2nd Ave South

3. NAME OF DECEASED (Type or Print)
a. (First) DANIEL
b. (Middle) E.
c. (Last) RYAN

4. DATE OF DEATH (Month) (Day) (Year) August 10,1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH October 17,1875
9. AGE (In years last birthday) 93
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 28
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ackley, Iowa
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Daniel Ryan
BIRTHPLACE Ireland
14. MOTHER'S MAIDEN NAME Bridget Hunt
BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 24 5211
17. INFORMANT'S OWN SIGNATURE x Mable E. Ryan
ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Generalized Arteriosclerosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Arrest
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Seconds

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [x]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 23, 1958, *to* August 10, 1969, *that I last saw the deceased alive on* August 9, 1969 19__, *and that death occurred at* 7a.m *m., from the causes and on the date stated above.*

23a. SIGNATURE Dean H. Affleck (Degree or title) M.D.
23b. ADDRESS 231 4th Avenue North Twin Falls, Idaho
23c. DATE SIGNED 8.11.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-12-1969
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 8/13/69
REGISTRAR'S SIGNATURE Vera Ryals
25. EMBALMER Donald J. Hamilton
LICENSE NO. 470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 1 9 1969

MAY 2 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3923
Local Reg. No. D-965
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 15 1969 Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls, 83301
d. STREET ADDRESS (If rural, give location): 303½ Polk Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	SAMILDA	MORDA	SHAFFER	August 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Widowed	Nov. 8, 1877	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Curtis R. Galloway	UNK	Troyer	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		518-60-3159	X Harold Shaffer	Twin Falls

4339

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 30, 19 69, *to* August 10, 1969, *that I last saw the deceased alive on* August 10 19 69, *and that death occurred at* 9:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean H. Affleck MD	231 4th Avenue North Twin Falls, Idaho 83301	8-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 13, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/13/69	Vera Ryals	Donald D. Hamilton	E-470

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3924
Local Reg. No. D-272
Reg. Dist. No. 460

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 130 East Ave. "D"

3. NAME OF DECEASED (Type or Print)
a. (First): OSCAR
b. (Middle):
c. (Last): FORT

4. DATE OF DEATH (Month) (Day) (Year): Aug. 11, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 15, 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dept. of Employment
10b. KIND OF BUSINESS OR INDUSTRY: State
11. BIRTHPLACE (State or foreign country): Berryville, Arkansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William L. Fort — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Alice Flora Evans — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. I
16. SOCIAL SECURITY NO.: 518 09 2994
17. INFORMANT'S OWN SIGNATURE: x Mrs. Hester Fort — ADDRESS: Jerome, Ida.

2509

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemmorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) thrombocytopenic Purpura — 1 mo +
DUE TO (c) Diabetes mellitus — yr

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-28, 1969, *to* 8-11, 1969, *that I last saw the deceased alive on* 8-11, 1969, *and that death occurred at* 1:04P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Elwood T. Rees MD
23b. ADDRESS: Twin Falls Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: August 22, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Glen S. Siren
LICENSE NO.: E-498

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 09 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3925
Local Reg. No. D-291
Reg. Dist. No. 460

RECEIVED AUG 18 1969 Bureau of Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 83316
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 83316
d. STREET ADDRESS (If rural, give location): Harral Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FLORENCE	C.	HARMON	August 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widow	Feb. 23, 1879	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife		Joliet, Illinois	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
(unknown)		(unknown)	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-40-9838	* Buster Harmon	Hansen Idaho

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — years
DUE TO (c) Generalized Arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 8, 1963, *to* Aug. 11, 1969, *that I last saw the deceased alive on* July 28, 1969, *and that death occurred at* 10:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. W. Cullins MD	Buhl, Idaho	8.14.69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8.15.69	Filer IOOF Cem.	Filer, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-15-69	Vera Ryals	Ronald J. Hamilton	E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG 15 1969

Certificate of Death

STATE OF IDAHO

State File No. 3926
Local Reg. No. D-968
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 203 4th St. North

3. NAME OF DECEASED (Type or Print): a. (First) VUNE b. (Middle) L. c. (Last) LARSON

4. DATE OF DEATH (Month) (Day) (Year): August 11, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 18, 1888

9. AGE (In years last birthday): 81 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Osceola, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-07-9333

17. INFORMANT'S OWN SIGNATURE: E. Larson ADDRESS: Twin Falls, Id.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4270

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 72 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 6 weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 19 66, *to* August, 19 69, *that I last saw the deceased alive on* 8-10, 19 69, *and that death occurred at* 2:30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. Theodore Scholes (Degree or title) MD
23b. ADDRESS: 120 Adams, Twin Falls, Ida.
23c. DATE SIGNED: 8-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: 8/13/69
REGISTRAR'S SIGNATURE: Vera Ryals
25. EMBALMER: Edgar J. Robertson LICENSE NO.: E-507
FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3927
Local Reg. No. D-373
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
AUG 26 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls (42)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. (143)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California (05)
b. COUNTY: Tulare (555)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Visalia 93277
d. STREET ADDRESS (If rural, give location): 916 West Main

3. NAME OF DECEASED (Type or Print)
a. (First): EMMA
b. (Middle): J.
c. (Last): ROSE

4. DATE OF DEATH: (Month) (Day) (Year): August 16, 1969

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 23, 1899

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Herman
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Anna Olson
BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 545-44-2041

17. INFORMANT'S OWN SIGNATURE: Mrs. [illegible] Per Telephone Via Calif.
ADDRESS:

18. CAUSE OF DEATH 4109

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-6- , 1969, *to* 8-16 , 1969, *that I last saw the deceased alive on* 8-16- , 1969, *and that death occurred at* 10:45A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James H. Speffard MD
23b. ADDRESS: 284 Martin St. Twin Falls, Idaho 83301
23c. DATE SIGNED: 8-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Aug. 17, '69
24c. NAME OF CEMETERY OR CREMATORY: Clovis Cemetery
24d. LOCATION (City, town, or county) (State): Clovis, California

DATE REC'D BY LOCAL REG.: August 22, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Edgar J. Robertson
LICENSE NO.: E-507
FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

AUG 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to:

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3928
Local Reg. No. D-277
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
V. LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) R.F.D. # 3

3. NAME OF DECEASED (Type or Print)
a. (First) GARY
b. (Middle) LYNN
c. (Last) MEISSNER

4. DATE OF DEATH (Month) (Day) (Year) Aug. 18, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Sept. 21, 1952
9. AGE (In years last birthday) 16 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ray E. Meissner — BIRTHPLACE Maywood, Nebraska
14. MOTHER'S MAIDEN NAME Elaine M. Fassler — BIRTHPLACE Bladen, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-58-7908
17. INFORMANT'S OWN SIGNATURE Ray Meissner — ADDRESS RFD # 3 Buhl, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8188

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive chest trauma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractured ribs and Scapula
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: approx one hr.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) County Road 06
21c. (CITY, TOWN, OR TOWNSHIP) Buhl 420 — (COUNTY) Twin Falls — (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 18, 1969 About noon m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Thrown off truck loaded with straw bales

22. *I hereby certify that I attended the deceased from* Investigation only, *19*__, *to* _____, *19*__, *that I last saw the deceased alive on* —, *19*__, *and that death occurred at* 1:14 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Twin Falls 583 3 4 (Degree or title) Cloyce O. Edwards County Coroner
23b. ADDRESS RFD # 3 Twin Falls, Idaho
23c. DATE SIGNED 8/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/21/69
24c. NAME OF CEMETERY OR CREMATORY Buhl
24d. LOCATION (City, town, or county) Buhl — (State) Idaho

DATE REC'D BY LOCAL REG. August 28, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER George Farmer — LICENSE NO. E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALBERTSON—DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3929
Local Reg. No. D-276
Reg. Dist. No. 460

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 AUG 26 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) 4 Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazel Del Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 327 Dubois

3. NAME OF DECEASED (Type or Print)
a. (First) GRACE
b. (Middle) ETHEL
c. (Last) HENDRICKS

4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH June 9, 1889
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Rock — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Louvisa Jane Crosby — BIRTHPLACE Unkn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - - - -
16. SOCIAL SECURITY NO. 519-09-7783D
17. INFORMANT'S OWN SIGNATURE Mrs Lillian Humphrey — ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility —

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Recent stroke —

DUE TO (c) Wage —

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1959, *to* Aug 20, 1969, *that I last saw the deceased alive on* Aug 17, 1969 *and that death occurred at* 3 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] Md.
23b. ADDRESS 542 Main South
23c. DATE SIGNED Aug 22 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 8-23-69
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Aug. 22, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Dale P. Patterson — LICENSE NO. E-451

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3930
Local Reg. No. D-279
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
c. LENGTH OF STAY (in this place): 4 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mountainview Nursing Home 247

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 430
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Murtaugh
d. STREET ADDRESS (If rural, give location): *********

3. NAME OF DECEASED (Type or Print)
a. (First): Joseph
b. (Middle): Henry
c. (Last): Egbert

4. DATE OF DEATH (Month) (Day) (Year): August 21 1969

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 8, 1889
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer 64
10b. KIND OF BUSINESS OR INDUSTRY: agriculture
11. BIRTHPLACE (State or foreign country): Kaysville, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME / BIRTHPLACE: David Kinyon Egbert-Kaysville, Ut.
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Emma Bone Kaysville, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-12-6694-G
17. INFORMANT'S OWN SIGNATURE / ADDRESS: Mary E. Egbert, Murtaugh

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*
(a) Bronchopneumonia filated — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardio-vascular disease — 20 yrs
DUE TO (c) Senility — Obesity

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1965, *to* 8-20, 1969 *that I last saw the deceased alive on* 8-20, 1969 *and that death occurred at* 8:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 460
23b. ADDRESS: Twin Falls
23c. DATE SIGNED: 8-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 8/25/69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls Idaho

DATE REC'D BY LOCAL REG.: August 28, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 3931 D-1283
Local Reg. No.
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 83328
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 608 Adel Street 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 420
d. STREET ADDRESS (If rural, give location) 608 Adel Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GEORGE	D.	WALKER	August 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Caucasian	Married	Aug. 1, 1899	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plant Manager 26	Seed Company	Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Walker	Indiana	Mary Edens	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-09-2814	x Mrs George D. Walker	Filer

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Insufficiency — Minutes
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 10:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Joyce O. Edwards	Coroner	RT#3 Twin Falls, Ida.	Sept 1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/27/69	Filer IOOF Cemetery	Filer, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 3, 1969	Marva D. Marsh	Edgar J. Robertson	E-[redacted]

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
SEP 4 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3932
Local Reg. No. D-280
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (In this place): 2 Months

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205
d. STREET ADDRESS (If rural, give location): 811 Aiken Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
STELLA	MAY	RATHBUN	August	24	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	April 4, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Cherokee County, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Aaron Strange	Kansas	Hattie Couse	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-42-1822	Duane D. Rathbun RFD #1	Filer Id.

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart Failure from — INTERVAL BETWEEN ONSET AND DEATH: 1 mon

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease Cerebral Sclerosis — sev. yrs.
DUE TO (c) Residual from Sept Stroke Hemiplegia. — 1 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 2 *, 19*69 *to* Aug 24 *, 19*69 *, that I last saw the deceased alive on* July 23 *, 19*69 *, and that death occurred at* 8:20 a.m. *, from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H. Anderson M.D.		Buhl, Ida	8-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/27/69	Buhl	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 2, 1969	Marva D. Marsh	George Farmer	E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3933
Local Reg. No. D-282
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Albion
d. STREET ADDRESS (If rural, give location): **********

3. NAME OF DECEASED (Type or Print)
a. (First): Myrtle
b. (Middle): Adams
c. (Last): Carlson

4. DATE OF DEATH (Month) (Day) (Year): Aug. 25, 1969

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 25, 1889
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): American Fork, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Joseph S. Adams - American Fork, Ut.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Jane Rushton - American Fork, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-36-3668
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Marijane Jolley — Albion

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart failure + Mesenteric artery infarction
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Diffuse Arteriosclerosis ~~Arteriosclerosis heart~~
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/19, 1969, *to* 8/25, 1969, *that I last saw the deceased alive on* 8/25, 1969, *and that death occurred at* 1:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Russell W. Newcomb MD 881
23b. ADDRESS: 666 Shoshone Street
23c. DATE SIGNED: 29 Aug 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 28, 1969
24c. NAME OF CEMETERY OR CREMATORY: Albion Masonic Cemetery
24d. LOCATION (City, town, or county) (State): Albion, Idaho

DATE REC'D BY LOCAL REG.: September 3, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: [signature]
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 4 1969 Bureau of Vital Statistics

State File No. 3934
Local Reg. No. D-285
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1953 San La Rue	d. STREET ADDRESS (If rural, give location) 1953 San La Rue

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last): LORAN WADE CARTER MASONER

4. DATE OF DEATH (Month) (Day) (Year): Aug. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
Male	White	Single	Aug. 14, 1951	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	School	Rupert, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
K. E. Masoner	Rupert, Idaho	Donna Carter	Provo, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	518-62-2628	K. E. Masoner	Twin Falls, Idaho

9229

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Exsanguination	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Gun shot wound in chest	minutes
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 421 (COUNTY) (STATE)
Accident	Home 31	Twin Falls, Twin Falls, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug. 27th, 1969 1:00 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Unknown

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Cloyce O. Edwards SF3	Coroner	R#3 Twinfalls, Ida.	Sept 1-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 30, 1969	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 3, 1969	Marva D. Marsh	Ronald J. Hamilton	E-470

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3935
Local Reg. No. D-293
Reg. Dist. No. 460

BIRTH NO.

RECEIVED SEP 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print) a. (First) PAUL b. (Middle) c. (Last) PUFAHL

4. DATE OF DEATH (Month) (Day) (Year) August 27, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Feb. 27, 1910

9. AGE (In years last birthday) 59
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Corvallis, Oregon

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME unknown
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME unknown
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW2 US Army

16. SOCIAL SECURITY NO. 519-07-8775

17. INFORMANT'S OWN SIGNATURE * Glenn Pufahl ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — unknown
DUE TO (c) Gen. arteriosclerosis — unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-7-63, 19____, to 8-27-69, 19____, that I last saw the deceased alive on 8-27-69, 19____, and that death occurred at 4:30A. m., from the causes and on the date stated above.

23a. SIGNATURE Willard H. Clark M.D. (Degree or title)

23b. ADDRESS TwinFalls, Idaho

23c. DATE SIGNED 8.28.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 30

24b. DATE 30 Aug. 1969

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial ParkCem.

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. September 9, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Jerry D. Holman

LICENSE NO. E-516

FIRM NAME White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 12 1969
SEP 17 1969
SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3936
Local Reg. No. D-289
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 SEP 8 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Twin Falls 421

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 Bureau of Vital Statistics

c. LENGTH OF STAY IN HOSPITAL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

d. STREET ADDRESS (If rural, give location) 375 Pierce Street

3. NAME OF DECEASED (Type or Print) a. (First) FLORENCE b. (Middle) E. c. (Last) BOGUSLAWSKI

4. DATE OF DEATH (Month) (Day) (Year) AUGUST 28, 1969

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH March 5, 1922

9. AGE (In years last birthday) 47 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) French Town, Ohio

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Delroy Barga BIRTHPLACE Ohio

14. MOTHER'S MAIDEN NAME Adeline M. Marshall BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-18-7007

17. INFORMANT'S OWN SIGNATURE Frank Boguslawski ADDRESS Twin Falls Ida

18. CAUSE OF DEATH 1830
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Abdominal carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 1 year

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bilateral ovarian carcinoma — 3½ years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 29 January, 1968, *to* 28 August, 1969, *that I last saw the deceased alive on* 28 August, 1969, *and that death occurred at* 3:45P. *m., from the causes and on the date stated above.*

23a. SIGNATURE James H. Spofford 489 (Degree or title) M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 8.29.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8.30.69

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. September 5, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Ronald J. Hamilton

LICENSE NO. E-470

FIRM NAME White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 10 1969
FEB 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3937
Local Reg. No. D-281
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): (Rural) Hollister
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 93 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: Riverside 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riverside
d. STREET ADDRESS (If rural, give location): 4662 Beatty Dr.

3. NAME OF DECEASED (Type or Print)
a. (First): NAOMI
b. (Middle):
c. (Last): COOK

4. DATE OF DEATH (Month) (Day) (Year): Aug. 29, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 16, 1908
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookeeper 19
10b. KIND OF BUSINESS OR INDUSTRY: Business Service
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank A. Brown — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Florence Swartz — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - - - -
16. SOCIAL SECURITY NO.: 558-34-9472
17. INFORMANT'S OWN SIGNATURE: Huntington Beach Calif. Howard W. Cook — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fractured skull — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Massive Head Trauma — minutes
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Massive chest injurys

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 93 06
21c. (CITY, TOWN, OR TOWNSHIP) 420 (COUNTY) (STATE): 3 Mi. South, Hollister, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 29 1969 2:45 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile accident

22. *I hereby certify that I ~~attended the deceased from~~* Made Investigation, 19__, ~~[illegible]~~ *on* August 29 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lloyce O. Edwards 583 Coroner
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: Sept. 2-1969

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3
24b. DATE: Sept. 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: Callahan-Jurupa Valley Mortuary
24d. LOCATION (City, town, or county) (State): Rubidoux, Calif.

DATE REC'D BY LOCAL REG.: Sept. 2, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Dale P. Patterson
LICENSE NO.: E-451

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Edwards

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3938
Local Reg. No. D-287
Reg. Dist. No. 460

BIRTH NO.

SEP 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 421 Twin Falls	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Nevada 29 b. COUNTY Elko 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (If in place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jcakpot
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 143 Magic Valley Mem. Hospital	d. STREET ADDRESS (If rural, give location) P.O. Box 303

3. NAME OF DECEASED (Type or Print)	a. (First) Daniel	b. (Middle) George	c. (Last) Danuser Jr.	4. DATE OF DEATH (Month) (Day) (Year) August 29, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 2, 1947	9. AGE (In years last birthday) 22 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender --Cactus 23	10b. KIND OF BUSINESS OR INDUSTRY Petes-Jackpot.	11. BIRTHPLACE (State or foreign country) Sacramento, California	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel G. Danuser	BIRTHPLACE California	14. MOTHER'S MAIDEN NAME Effie M. Westgarth--	BIRTHPLACE Colorado	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 10-4-1965 to 10-7-1966 (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 560-66-4984	17. INFORMANT'S OWN SIGNATURE X Delores K. Danuser	ADDRESS Jackpot, Nevada	

8 8129

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) *This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive Chest Trauma	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Auto Accident	30 Min
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident-U.S. 93-5½	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Misse So.	21c. (CITY, TOWN, OR TOWNSHIP) 420 (COUNTY) (STATE) Of Hollister Twin Falls, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 29, 1969 2:20 P.M.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Two Car Accident

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Cloyce O. Edwards 583 (Degree or title) Coroner	23b. ADDRESS R #3 Twin Falls, Ida	23c. DATE SIGNED Sept 2-1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-2-1969	24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	24d. LOCATION (City, town, or county) Gooding, (State) Idaho
DATE REC'D BY LOCAL REG. September 4, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Eddie G. Peach	LICENSE NO. E-511

FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 10 1969

AUG 08 2005

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3939
Local Reg. No. D-284
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls (42)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: 361 7th Ave. E. COD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho (13)
b. COUNTY: Twin Falls (42)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 361 7th Ave. E.

3. NAME OF DECEASED (Type or Print): a. (First) ELPHA b. (Middle) I. c. (Last) HUNT

4. DATE OF DEATH: (Month) (Day) (Year) Aug. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Aug. 25, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	Montezuma, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
I. N. Covault	Ohio	Catherine Florence Jones	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	518-36-5666B	[signature]	Twin Falls, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 6, 19 54 *to* August 29, 19 69, *that I last saw the deceased alive on* August 29, 19 69, *and that death occurred at* 4:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean H Ashleck MD	231 4th Avenue North Twin Falls, Idaho	2 Sept. 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 2, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 3, 1969	Marva D. Marsh	Edgar J. Overton	E-507

FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3940
Local Reg. No. D-286
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 8 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: T. Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Hansen
d. STREET ADDRESS (If rural, give location): R.R.#1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HOBART	L.	MUSSON	August 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	January 11, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04		Hawarden, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Willis H. Musson	Minnesota	Hattie Mae Ellsberry	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	516-44-3296	Hansen, Mattie Musson	Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. acute urinary retention; Adenocarcinoma of Prostate gland with

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
—	—	

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 28, 19 69 *to* August 29, 19 69, *that I last saw the deceased alive on* August, 19 69, *and that death occurred at* 10005p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
George Davis M.D. (Degree or title)	Twin Falls, Idaho	9/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	9/1/69	Geraldine Cemetery	Geraldine, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 4, 1969	Marian D. Marsh	James C. Reynolds, James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 9 1969
JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3941
Local Reg. No. D-308
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: T. Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 629 Morningside Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MABLE	ELLEN	KIRKPATRICK	August 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	August 26, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Quincy, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Hyde	Illinois	Maude	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
no	519-44-9268	Keith Kirkpatrick Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Occulsion	1 hr.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute pulmonary Edema	1 hr.
DUE TO (c)	Arteriosclerotic heart disease	10 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* 8/31/____, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 9:30a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. Ellis Kirkpatrick M.D.	Kimberly, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/3/69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 18, 1969	Marva D. Mason	Paul D. Reynolds	E-495

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Reynolds Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3942
Local Reg. No. D-290
Reg. Dist. No. 460

BIRTH NO. 69-8582

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Twin Falls (42) SEP 8 1969 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls STAY (In this place): d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. (143)	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Twin Falls (42) b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 d. STREET ADDRESS (If rural, give location): 465 No. Ostrander

3. NAME OF DECEASED (Type or Print): a. (First) Infant b. (Middle) (Ronald Dean) c. (Last) Tennant	4. DATE OF DEATH (Month) (Day) (Year): Aug. 31, 1969					
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single	8. DATE OF BIRTH: Aug. 31, 1969	9. AGE (In years last birthday): Newborn	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.: 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (92)	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Robert L. Tennant	BIRTHPLACE: Idaho	14. MOTHER'S MAIDEN NAME: Donna Tucker	BIRTHPLACE: Idaho			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----	16. SOCIAL SECURITY NO.: ----	17. INFORMANT'S OWN SIGNATURE: [signature]	ADDRESS: Twin Falls, Idaho			

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	7599 Neonatal Atelectasis	1 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)	Multiple Congenital abnormalities Hydrocephalus, Syndactylism	id
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Lt hand & foot, Rt Equinovarus congenital heart disease Prematurity	1d

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?		

22. *I hereby certify that I attended the deceased from* 8/31, 1969, *to* 8/31, 1969, *that I last saw the deceased alive on* 8/31, 1969, *and that death occurred at* 8:25p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Tom Wright	(Degree or title): MD	23b. ADDRESS: Twin Falls, Idaho	23c. DATE SIGNED: Sept. 4, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 3, 1969	24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho	
DATE REC'D BY LOCAL REG.: September 5, 1969	REGISTRAR'S SIGNATURE: Marva D. Marsh	25. EMBALMER: Jerry D. Holman		LICENSE NO.: E-516

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: White Mortuary - Twin Falls, Idaho

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3943
Local Reg. No. 7
Reg. Dist. No. 318

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Valley 430 AUG 2 8 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall c. LENGTH OF STAY (In this place) 30 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home 0220	d. STREET ADDRESS (If rural, give location) Box 268

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SILVIA	A.	HAYES	August 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	August 16, 1906	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		McCall, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Paananen	Finland	Maria Maki	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-09-6833	Patrick J. Hayes	McCall, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	ACUTE BRONCHOSPASM AND ASPHYXIA	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	MALNUTRITION	

492X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 66, *to* AUGUST 15, 19 69, *that I last saw the deceased alive on* AUGUST 15, 19 69, *and that death occurred at* 10:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ronald S. Nokes M.D.	McCall, Idaho	8-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug 18, 1969	McCall Cemetery	McCall Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 22-1969	Myrtle M. Gardner	Burton E. Walker	E-386

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 2 9 1969
AUG 1 8 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 1 4 1979
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3944
Local Reg. No. 8
Reg. Dist. No. 3/8

69-6835
BIRTH NO.

RECEIVED
AUG 28 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural McCall
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway-4 mi so McCall 4002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1919 Nixon Street

3. NAME OF DECEASED (Type or Print): a. (First) TAMI; b. (Middle) RENAE; c. (Last) COLLINS

4. DATE OF DEATH (Month) (Day) (Year): August 19, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): infant

8. DATE OF BIRTH: July 20, 1969

9. AGE (In years last birthday): IF UNDER 1 YR. Months / Days: 30; IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant 92

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rodney Collins — BIRTHPLACE: Sunnyside, Washington

14. MOTHER'S MAIDEN NAME: Carol Doty — BIRTHPLACE: Moscow, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Rodney Collins — ADDRESS: Caldwell, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8181

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): crushing injuries to head — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Hiway #55- so. McCall 66

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): McCall 430 Valley Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 19, '69 11 A. M.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: fell from moving automobile, struck by rear wheels

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton C Walker, Coroner 553 4 — **23b. ADDRESS**: McCall, Idaho — **23c. DATE SIGNED**: 8/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 22, '69

24c. NAME OF CEMETERY OR CREMATORY: Freeze Cemetery

24d. LOCATION (City, town, or county) (State): Palouse, Washington

DATE REC'D BY LOCAL REG.: Aug-26-1969

REGISTRAR'S SIGNATURE: Myrtle M Gardner

25. EMBALMER: Burton C Walker

LICENSE NO.: E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-69021

SEP 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3945
Local Reg. No. 9
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Valley 430 SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (In this place) 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location) Box 149

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SAMUEL	E.	DEFLER	August 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	November 23, 1913	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supervisor - Payette National Forest		Titusville, New York	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William A. Defler	New York	May Dix	Oriskany Falls, N. Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Wm A Defler	Whitefish, Montana

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1918

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Astrocytoma L side of brain — INTERVAL BETWEEN ONSET AND DEATH: 3 mos +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb, 1962, to Aug 25, 1969, that I last saw the deceased alive on Aug 25, 1969, and that death occurred at 247P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James H Stewart MD	McCall Idaho	8/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation 2	Aug 28, 1969	Mt. View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept-2 1969	Myrtle M. Gardner	Burton C. Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DR-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 8 1969

MAR 1 6 1970

MAR 3 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 2 8 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3946
Local Reg. No. 10
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural McCall
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7 mi. S W of McCall 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print): a. (First) LLOYD; b. (Middle) ALFRED; c. (Last) MOUDY

4. DATE OF DEATH (Month) (Day) (Year): August 30, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: May 7, 1918

9. AGE (In years last birthday): 51
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Long Valley Farms

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: E. D. Moudy
BIRTHPLACE: near Middleton, Idaho

14. MOTHER'S MAIDEN NAME: Lilliam Morrow
BIRTHPLACE: Caldwell, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W W 2 4

16. SOCIAL SECURITY NO.: 518-14-7020

17. INFORMANT'S OWN SIGNATURE: Ed Moudy
ADDRESS: McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): apparent coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): coronary disease history — approx. 10 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): natural

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 7 mi S. W. McCall

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): McCall, Valley Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8/30/69-approx noon m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: attack occurred while irrigating in field

22. *I hereby certify that I attended the deceased from* _____ *19__ to* _____ *, 19__, that I last saw the deceased alive on* _____ *, 19__, and that death occurred at* _____ *m., from the causes and on the date stated above.*

INVESTIGATION ONLY

23a. SIGNATURE (Degree or title): Burton C Walker SS 4, Coroner

23b. ADDRESS: McCall, Idaho

23c. DATE SIGNED: Sept 4, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Sept 4, 1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill

24d. LOCATION (City, town, or county) (State): Caldwell Idaho

DATE REC'D BY LOCAL REG.: Sept-9-1969

REGISTRAR'S SIGNATURE: Myrtle M Gardner

25. EMBALMER: Burton C Walker

LICENSE NO.: E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
FORM DH-63021

SEP 18 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 3947
Local Reg. No. 9
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
SEP 4 1969
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington 44
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hosp. 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 44
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): VERA
b. (Middle): N.
c. (Last): BARTON

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1-17-1890
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months 6, Days 22 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): LaGrande, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew J. Gibbs — BIRTHPLACE: ---------
14. MOTHER'S MAIDEN NAME: Anna Elizabeth Dalton — BIRTHPLACE: ---------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: x Fred Barton Jr. — ADDRESS: Cambridge, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypostatic Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): C.V.A.
DUE TO (c): Cerebral Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24-69, *to* 8-9-69, *that I last saw the deceased alive on* 8-9-69, *and that death occurred at* 10:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M S McGrath MD
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: Aug. 9, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 8-12-69
24c. NAME OF CEMETERY OR CREMATORY: Cambridge,
24d. LOCATION (City, town, or county) (State): Cambridge, Idaho

DATE REC'D BY LOCAL REG.: 8-11-69
REGISTRAR'S SIGNATURE: R. Dave Thomason
25. EMBALMER: R. Dave Thomason
LICENSE NO.: E-388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3948
Local Reg. No. 12
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Midvale
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Frank	--	Sutton	8	28	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	married	8/20/1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher	agriculture	Fair Play, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Reuben R. Sutton	Kentucky	Mary Viola Jarnagin	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW I		x Ward Sutton	Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chr Nephritis
DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gastric Hemorrhage

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-24-69, *to* 8-28-69, *that I last saw the deceased alive on* 8-28-69, *and that death occurred at* 10:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. D. McGeath MD 344	Weiser, Idaho	8/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9/2/69	Eastside Cemetery	Midvale, Washington, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-2-69	K. Dee Thomsen	K. Dee Thomsen	E 388

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 16 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 8 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3949
Local Reg. No. 12
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Weiser
c. LENGTH OF STAY (In this place): 193
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
441
d. STREET ADDRESS (If rural, give location): 331 E. Park

3. NAME OF DECEASED (Type or Print): a. (First) Edna; b. (Middle); c. (Last) Bain

4. DATE OF DEATH (Month) (Day) (Year): August 30, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 23, 1882

9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Fort Collins, Colorado

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Thomas Jesse Honnold
BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: Susan Harris
BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Melvin B. Bain
ADDRESS: Potlatch, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive G. I. Hemm — INTERVAL BETWEEN ONSET AND DEATH: 12 h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prob. duod ulcer — 1 W
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. A. H. T. Dis., Rheum arthritis

5329

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/27, 1965, *to* 8/30, 1969, *that I last saw the deceased alive on* 8/30, 1969 *and that death occurred at* 2:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 186

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: Aug. 30, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 3, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Weiser, Idaho

DATE REC'D BY LOCAL REG.: Aug. 30, 1969

REGISTRAR'S SIGNATURE: R. Dale Thomason

25. EMBALMER: R. Dale Thomason
LICENSE NO.: E-388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3950
Local Reg. No. 133
Reg. Dist. No. 371

BIRTH NO.

OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) LUCK PEAK DAM AREA
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUCKY PEAK DAM AREA 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO
b. COUNTY ADA 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) PHILLIP MICHAEL BORGEMAN

4. DATE OF DEATH (Month) (Day) (Year) APRIL 27, 1969

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED
8. DATE OF BIRTH JAN.6, 1956
9. AGE (In years last birthday) 13 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME THOMAS RODERICK BORGEMAN BIRTHPLACE McCALL, IDAHO
14. MOTHER'S MAIDEN NAME MARDELL CAMPBELL BIRTHPLACE LARAMIE, WYOMING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE ADDRESS X Mardell J Borgeman

18. CAUSE OF DEATH 9100
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Asphyxiation by Drowning. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Subject to Epilepsy Convulsions.
DUE TO (c) Body not located for 5 months.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13010

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, that I last saw the deceased alive on _____ 19____, and that death occurred at* 9 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 583 (Degree or title) Coroner
23b. ADDRESS 3720 Meadow Drive. Boise.
23c. DATE SIGNED 10-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-69 9-30-69
24c. NAME OF CEMETERY OR CREMATORY Pleasant Valley
24d. LOCATION (City, town, or county) Canyon County, (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 13, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Grant
LICENSE NO. 478E

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Coroner

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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amend 11-23-81

Certificate of Death
STATE OF IDAHO

State File No. 3951
Local Reg. No. 187
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
SEP 5 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Ada

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho

c. LENGTH OF STAY (In this place): 4 years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Nursing Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Ada

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho

d. STREET ADDRESS (If rural, give location): 512 East 46th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Frank	Brock	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 14, 1893	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Same	Shellknob Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Amos Brock	Missouri	Barbra Jane Ledgerwood	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	519-10-0286A	Charles F Brock	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

582X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral vascular obstruction — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertension — 5 years

DUE TO (c) Chronic nephritis — 10 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 15, 1968, *to* Sept 1, 1969, *that I last saw the deceased alive on* Aug 15, 1969, *and that death occurred at* 4 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Rogers 550 Ward MD	Boise, Ida	9/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-5-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 5 1969	Myrtle Palmer	Eldon Bryan Bysam	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

SEP 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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11-18-81

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of _____ } ss.
County of _____ }

Certificate No. 69-3951
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of death

for John Frank Breck (Name on Original Certificate) who died (Was Born, Died, etc.) on 9-1-69 (Date of Event)

in Boise (Ada) (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
deceased last name	Breck	Brock

Subscribed and sworn to before me this _____ day of _____, 19__.

Notary Public, _____
Residing at _____
My commission expires _____
(Seal)

Darla Leavitt
Signature of Applicant
3364 Brompton Way 83702
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ } ss.
County of _____ }

(Must be completed __)
(Is not necessary __)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 21 day of NOVEMBER, 1981.

Notary Public, Charles F Brock
Residing at BOISE IDAHO
My commission expires 11-24-82
(Seal)

X Jo M. Mosier
Supporting Signature
1309 Vermont Ave
Street Address, City, State
Boise, Id. 83706

Type on certificate has all letter o's blurred so it was mistakenly taken as an e when it was put in books.

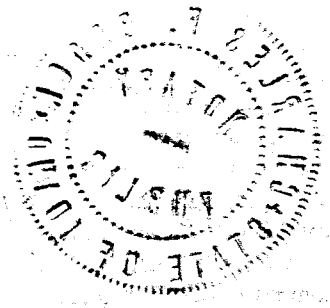

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3952
Local Reg. No. 108
Reg. Dist. No. 371

BIRTH NO.

SEP 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho c. LENGTH OF (Duration of this place) 3 Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset NNursing Home 235	d. STREET ADDRESS (If rural, give location) 3115 Sycamore Dr.

3. NAME OF DECEASED (Type or Print) a. (First) Amy	b. (Middle) S.	c. (Last) McCutcheon	4. DATE OF DEATH (Month) Sept (Day) 1, (Year) 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec.17, 1879	9. AGE (In years last birthday) 87 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (State or foreign country) Bellaire, Michigan	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Stewart	BIRTHPLACE Michigan	14. MOTHER'S MAIDEN NAME Adeline Holden	BIRTHPLACE Michigan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	X 17. INFORMANT'S OWN SIGNATURE Mrs Carl E. Whitmore	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease

~~DUE TO (c)~~ Right Hemiparesis Sec. to Cerebral artery Thrombosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1950, *to* Sept 1, 1969, *that I last saw the deceased alive on* 2-15, 1969 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Dr. John E. Cuffard md 094 (Degree or title)	23b. ADDRESS 311 - Idaho St	23c. DATE SIGNED 9/3/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-4-69	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Sept. 5 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Erle B. Byram	LICENSE NO. E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 3953
Local Reg. No. 579
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada — SEP 12 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Nursing Home 293

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ustick
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alma		Milks	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	May 31, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	St. Paul Park, Minn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eric M. Dahlberg	Sweden	Johanna Molander	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-54-2101	Wenda Onwiler	Ustick Rural Station

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic congestion of L. lung — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic bronchitis — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-25 19[illegible] *to* 9-1 19[illegible], *that I last saw the deceased alive on* 5-26, 19[illegible], *and that death occurred at* 12:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] MD	Boise Idaho	9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Entombment	Sept. 3, 1969	Morris Hill Maus.	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 11, 1969	Myrtle Palmer	[illegible]	E-422

FIRM NAME: Alden Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 12 1969

OCT 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 4 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 12 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED SEP 24 1969 Bureau of Vital Statistics

State File No. 3954
Local Reg. No. 608
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 319 East 3rd Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ARTHUR	A.	SHEAFFER	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 24, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	bakery	Coon Rapids, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William J. Sheaffer	Pennsylvania	Sarah I. Creswell	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-36-1014	Emma B. Sheaffer	319 E. 3rd. Meridian, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: approx 2wks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic pulm. emphysema — many years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
Generalized arteriosclerosis — many years
Inactive aortic valvulitis (rheum) — many years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 30 Aug, 1969, to 1 Sept, 1969, that I last saw the deceased alive on 1 Sept, 1969, and that death occurred at 11:50 PM., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	6003 Overland Boise Ida.	23 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-4-69	Glenn Rest Cemetery	Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 24 1969	Myrtle Palmer	[signature]	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3955
Local Reg. No. 567
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): Lear	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 804 Warren--At Home 000	d. STREET ADDRESS (If rural, give location): 804 Warren

3. NAME OF DECEASED (Type or Print) a. (First): HOMER	b. (Middle): C.	c. (Last): BARNETT	4. DATE OF DEATH (Month) (Day) (Year): Sept. 2, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: May 6, 1913	9. AGE (In years last birthday): 56 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender 23	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Grangeville, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Robert Barnett	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Francis Weatherford	BIRTHPLACE: Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W W II 2	16. SOCIAL SECURITY NO.: 518-03-5443	17. INFORMANT'S OWN SIGNATURE: 804 Warren x Mrs Bea Barnett	ADDRESS: Boise, Ida.	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Thrombosis.	Brief.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Bad Attack recently.	3 Weeks
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at* 830 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 E. D. Paris 4 (Degree or title): Coronar	23b. ADDRESS: 3720 Meadow Drive, Boise.	23c. DATE SIGNED: 9-3-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 6, '69	24c. NAME OF CEMETERY OR CREMATORY: Grangeville Cem.	24d. LOCATION (City, town, or county): Grangeville (State): Idaho
DATE REC'D BY LOCAL REG.: Sept. 4, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Gary A. Cowger	LICENSE NO.: E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 22 1969

SEP 22 1969

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3956
Local Reg. No. 573
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho c. LENGTH OF STAY (In this place): 2 weeks	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Manor 293	d. STREET ADDRESS (If rural, give location): 110 W. State

3. NAME OF DECEASED (Type or Print)	a. (First) E.	b. (Middle) Walton	c. (Last) Cahalan	4. DATE OF DEATH (Month) Sept. (Day) 2 (Year) 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: May 7, 1892	9. AGE (In years last birthday): 77	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk Mt. Home Air Base 05	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Emmett Cahalan	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-10-6380	17. INFORMANT'S OWN SIGNATURE: *Mrs. Dorothy E. Cahalan	ADDRESS		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary Artery Heart Disease

~~DUE TO (c)~~ Obstructive Pulmonary Emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Arterial Insufficiency

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* NOV, 1957, *to* Sept 2, 1969, *that I last saw the deceased alive on* 8-6, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Dr John E. Clifford MD 094 (Degree or title)	23b. ADDRESS: 311-Idaho St, Boise	23c. DATE SIGNED: 9/3/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-6-1969	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Sept. 5 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Eric B. Byram	LICENSE NO.: E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 1969
DEC 28 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 3957
Local Reg. No. 569
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 01 — SEP 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1419 N. 11th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2719 Fry St.

3. NAME OF DECEASED (Type or Print): a. (First) Emma — b. (Middle) B. — c. (Last) Talley

4. DATE OF DEATH (Month) (Day) (Year): Sept. 2, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Jan. 29, 1889

9. AGE (In years last birthday): 80
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Peoa, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Wardell — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Elvina Lucretia Barter — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-54- 0212

17. INFORMANT'S OWN SIGNATURE: Wilma L. Talley Thomas — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Probable congestive heart failure

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Probable Arteriosclerotic heart disease.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11/13, 1968, *to* 2/29, 1969, *that I last saw the deceased alive on* 2/29, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: O. L. Osborn 095 (Degree or title): M.D.

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 9/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/5/1969

24c. NAME OF CEMETERY OR CREMATORY: Sunset Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 5 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Earl Waggoner

LICENSE NO.: E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 5 - 1969
OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 17 1969 Bureau of Vital Statistics

State File No. 3958
Local Reg. No. 590
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — LENGTH OF STAY (In this place): 8 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 5605 Kootenai St.

3. NAME OF DECEASED (Type or Print) a. (First): Dorothy	b. (Middle): M.	c. (Last): Wartman	4. DATE OF DEATH (Month) (Day) (Year): Sept. 2, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: May 11, 1910	9. AGE (In years last birthday): 59 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Indian Valley, Ida.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: V. O. Sutton	BIRTHPLACE: Kansas	14. MOTHER'S MAIDEN NAME: Faye E. Morey	BIRTHPLACE: Nevada	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-36-0710	17. INFORMANT'S OWN SIGNATURE: X M Eugene Wartman	ADDRESS: Orofino Ida.	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1890

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic Renal cell carcinoma to brain.

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Renal cell carcinoma

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Lung & lymph node metastases

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/10, 1969, *to* 9/2, 1969, *that I last saw the deceased alive on* 9/2, 1969 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 045 (Degree or title) M.D.	23b. ADDRESS: Boise, Idaho	23c. DATE SIGNED: 9/9/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9/5/69	24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Memorial Gardens	24d. LOCATION (City, town, or county): Boise, (State) Idaho
DATE REC'D BY LOCAL REG.: Sept. 17, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: G. W. Waters [signature]	LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3959
Local Reg. No. 576
Reg. Dist. No. 370

BIRTH NO.

SEP 9 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): Minutes	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital	d. STREET ADDRESS (If rural, give location): 307 Hot Springs

3. NAME OF DECEASED (Type or Print) a. (First): EVELYN	b. (Middle): TERRY	c. (Last): SHURTZ	4. DATE OF DEATH (Month) (Day) (Year): Sept. 3, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Dec. 30, 1917	9. AGE (In years last birthday): 51 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Waneta, Nebraska	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Ora Nelson Terry BIRTHPLACE: Jameson, Missouri		14. MOTHER'S MAIDEN NAME: Bessie Edwards BIRTHPLACE: Nebraska		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: X Albert B. Shurtz ADDRESS		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

398X

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac arrest	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute pulmonary edema	1 hr
DUE TO (c)	Rheumatic Heart Disease	unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* Sept 3, 1969, *and that death occurred at* 1:25 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD	23b. ADDRESS: 425 W Bannock Boise	23c. DATE SIGNED: 9/8/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-3-69	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise Ada Idaho
DATE REC'D BY LOCAL REG.: Sept. 9, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Eldon T. Pearson	LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 9 - 1969

FEB 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. Losser
3113 W. State
343-0261

Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 3960
Local Reg. No. 584
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011 SEP 16 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Bureau of Vital Statistics c. LENGTH OF STAY (In this place): 1 Day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 5619 Lubkin

3. NAME OF DECEASED (Type or Print)	a. (First) Louise	b. (Middle) M.	c. (Last) Smithman	4. DATE OF DEATH (Month) Sept (Day) 3, (Year) 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Oct. 21, 1915	9. AGE (In years last birthday): 53 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): St. Paul Minn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Edmond Posch	BIRTHPLACE: Minn	14. MOTHER'S MAIDEN NAME: Erma Hounstein	BIRTHPLACE: Minn.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: X M.R. Smithman	ADDRESS: 1	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Infra Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cirrhosis.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/15, 1956 *to* 9/3, 1969, *that I last saw the deceased alive on* 9/3, 1969, *and that death occurred at* 8 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: Losser MD (Degree of title) 306	23b. ADDRESS: Boise Ida	23c. DATE SIGNED: 9/15/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-6-69	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Park	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Sept. 16, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Eric B. Byram	LICENSE NO.: E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 16 1969

3CC

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3961
Local Reg. No. 109
Reg. Dist. No. 371

BIRTH NO.

RECEIVED SEP 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 233 days 7 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): V.A.HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: OREGON 38
b. COUNTY: MALHEUR 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NYSSA
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ADOLPH	E.	SCHROEDER	SEPT. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	DIV.	FEB. 29, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CABINET MAKER - RETIRED	SAME	PRETTY PRAIRIE, KANSAS	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JACOB SCHROEDER	POLAND	ANNA UNRUH	POLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI	519 09 74 19	Eleanor L. Ewing	V.A.HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c). 1541

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic adenocarcinoma, rectum. — INTERVAL BETWEEN ONSET AND DEATH: 11 years

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I attended the deceased from 1-14, 1969, to 9-4, 19 69, that I last saw the deceased alive, and that death occurred at 6:40p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. W. Laxson W. W. LAXSON, M.D. 941	V.A.HOSPITAL, BOISE, IDAHO	9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	9-5-69		Nyssa, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 8 1969	Myrtle Palmer	Dale McMurphey	410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 5 1969

APR 17 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

APR 27 1976

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

OCT 7 1982

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 3962
Local Reg. No. 586
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 46 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1515 N. 19th.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1515 N. 19th. St.

3. NAME OF DECEASED (Type or Print)
a. (First): Maryette
b. (Middle): -
c. (Last): Seibel

4. DATE OF DEATH (Month) (Day) (Year): Sept. 4, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sep't. 20, 1889
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail firm 26
10b. KIND OF BUSINESS OR INDUSTRY: Falks
11. BIRTHPLACE (State or foreign country): Fort Benton, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James E. Walker — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Jennie L. Evans — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-22-6015
17. INFORMANT'S OWN SIGNATURE: Theodore Seibel — ADDRESS: 1515 N. 19th. Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive CV disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1964, 19__, *to* Sept, 1969, *that I last saw the deceased alive on* Aug 30, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. H. Hawley 216
23b. ADDRESS
23c. DATE SIGNED: 9/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Entombed
24b. DATE: 9/6/69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Mausoleum
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Sept. 15 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-527
FIRM NAME: Mountain View Funeral Home, Boise

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3963
Local Reg. No. 577
Reg. Dist. No. 870

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada SEP 10 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1412 South Arcadia

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BERNARD	JOSEPH	WELCH	Sept. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 8, 1915	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ticket Agent	Greyhound Bus Co.	Norfolk, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Patrick Welch	---	Eldorado Roundtree	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II	481-09-4880	Bernard J. Welch	1412 S. Arcadia Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease yrs
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 5-3 hours

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April, 1969, to 9-4, 1969, that I last saw the deceased alive on 9-4, 1969, and that death occurred at 12:55 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. D. Forney 173 M.D.	425 Bannock Boise	9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-6-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 10, 1969	Myrtle Palmer	Lowell H. Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP10 - 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3964
Local Reg. No. 593
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
SEP 18 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 26days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Carl	Ernest	Dunlap	September 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Dec. 9, 1902	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher	cattle	Ft. Collins, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clay M. Dunlap	Ohio	Fanny Herzler	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		721 14 2462A	X Hazel Dunlap	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemiplegia - Stroke — INTERVAL BETWEEN ONSET AND DEATH: 6 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of prostate

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-18-69	Bil orchiectomy	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January, 1969, *to* death, 19___, *that I last saw the deceased alive on* Sept 6, 1969, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Tom Jefferson 254	MD	Boise Idaho	9/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 11, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 17, 1969	Myrtle Palomer	Glenn W Beatty	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3965
Local Reg. No. 601
Reg. Dist. No. 270

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada — SEP 2 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (In this place): Unknown
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County RestHome 302

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 1715 North 16th

3. NAME OF DECEASED (Type or Print): a. (First) Eliza; b. (Middle); c. (Last) Henshaw

4. DATE OF DEATH: (Month) Sept (Day) 8 (Year) 69

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 6, 1866

9. AGE (In years last birthday): 103
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Heber City, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Charles Henry Wilchen — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Mary McOmie — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-62-9819

17. INFORMANT'S OWN SIGNATURE: Mrs. LaVerne Waits — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/9 , 19 69 , *to* 9/8 , 19 69 , *that I last saw the deceased alive on* 9/8 , 19 69 , *and that death occurred at* 1:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS

23c. DATE SIGNED: 9/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-11-69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Sept. 22, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Earl B. Byram

LICENSE NO.: E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED SEP 24 1969 Bureau of Vital Sc

STATE OF IDAHO

State File No. 3966
Local Reg. No. 599
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 7 Mos.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292	d. STREET ADDRESS (If rural, give location): 1122 Grand Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) LUTHER	b. (Middle) E.	c. (Last) JOHNSON	4. DATE OF DEATH (Month) Sept. (Day) 8 (Year) 1969	
5. SEX: Male	6. COLOR OR RACE: Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Mar. 21, 1883	9. AGE (In years last birthday): 86	IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance 10	10b. KIND OF BUSINESS OR INDUSTRY: Greyhound Bus	11. BIRTHPLACE (State or foreign country): Van Buren, Arkansas	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: W. P. Johnson	BIRTHPLACE: Tennessee	14. MOTHER'S MAIDEN NAME: Amanda	BIRTHPLACE: South Carolina		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-18-3024	17. INFORMANT'S OWN SIGNATURE: + Ellen Stevens	ADDRESS: 1628 Longmont Ave. Boise		

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Congestive heart failure	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Prostatic Carcinoma	

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 16, 1968, *to* September 6, 1969, *that I last saw the deceased alive on* September 6, 1969, *and that death occurred at* 1:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE: F. K. Root (Degree or title) M.D.	23b. ADDRESS: 6003 Overland Road	23c. DATE SIGNED: 9-15-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-12-69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cem.	24d. LOCATION (City, town, or county): Boise Ada (State): Idaho
DATE REC'D BY LOCAL REG.: Sept. 19 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Robert G. Lom	LICENSE NO.: E-497

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3967
Local Reg. No. 581
Reg. Dist. No. 370

BIRTH NO. RECEIVED SEP 16 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. STREET ADDRESS (If rural, give location) 110 Williams St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Marlin	C.	Littlefield	9 - 8 - 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	divorced	9-14-1913	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	same	Moran, Texas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Carrol	Texas	Mabel Harrelson	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes WWII + 985X	521-22-1163	X Marlin E Littlefield	Colo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gun Shot Wound to R temporal lobe

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Edenstein + ventricular brain	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Not KNOWN	31	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
9-7-69 m.		

22. I hereby certify that I attended the deceased from 9-7-69, 19__, to 9-8-69, 19__, that I last saw the deceased alive on 9-8, 19 69 and that death occurred at 7:35 P.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9-13-69	Memorial Gardens	Delta, Colorado

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 16, 1969	Myrtle Palmer	Jack H. Green	E-528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 6 1969

MAR 29 1971 JUN 1 6 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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MINER
1333 W Jefferson

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3968
Local Reg. No. 591
Reg. Dist. No. 370

BIRTH NO.

SEP 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho c. LENGTH OF STAY (In this place): 8 weeks	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital	d. STREET ADDRESS (If rural, give location): 1115 North Cole Rd.

3. NAME OF DECEASED (Type or Print) a. (First) William Augustin b. (Middle) Murphy c. (Last)			4. DATE OF DEATH (Month) Sept (Day) 8 (Year) 69	
5. SEX: male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Jan. 2, 1889	9. AGE (In years last birthday): 80 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Business	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Emmetsburg, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Patrick Murphy BIRTHPLACE: Unknown		14. MOTHER'S MAIDEN NAME: Jane Donahue BIRTHPLACE: Illinois		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Raymond J. Murphy ADDRESS: Boise		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: several yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary heart disease several yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-1, 1961, *to* 9-8, 1969, *that I last saw the deceased alive on* 9-8, 1969, *and that death occurred at* 11 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner 364 MD (Degree or title)	23b. ADDRESS: 1333 W. Jefferson Boise, Idaho	23c. DATE SIGNED: 9/17/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-12-69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho		
DATE REC'D BY LOCAL REG.: Sept. 17 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Erle B. Byram
LICENSE NO.: E-533		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 17 1969

SEP 18 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3969
Local Reg. No. 110
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
SEP 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 8 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN. HOSPITAL, BOISE, IDA.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 2322 SOUTH PACIFIC

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DONALD	T.	PAXTON	SEPTEMBER 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	MAY 26, 1911	58	-- / --	-- / --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	BUILDING	BLACKFOOT, IDAHO	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
EPH PAXTON	UTAH	SARAH GOODSON	IDAHO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWII	519-01-15-22	James Sentley	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Chronic obstructive pulmonary emphysema	3 years +
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Urethral stricture traumatic	14 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

VA

22. I attended the deceased from AUGUST 31, 1969, to SEPTEMBER 8, 1969, and that death occurred at 5:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree/Title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis M.D. 1597 ROBERT C. LEWIS, M.D.	VA CENTER, BOISE, IDAHO	9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 11, 1969	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 11, 1969	Myrtle Palmer	Conway Grant	E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 16 1969
SEP 7 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3970
Local Reg. No. 582
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. STREET ADDRESS (If rural, give location) 527 E. State Ave

3. NAME OF DECEASED (Type or Print) a. (First) Iva b. (Middle) L. c. (Last) Strellner
4. DATE OF DEATH (Month) (Day) (Year) 9 - 8 - 69
5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH 3-11-1884
9. AGE (In years last birthday) 85
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY same
11. BIRTHPLACE (State or foreign country) Hancock, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME J. W. Warner BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Victoria Griffith BIRTHPLACE Indiana
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 560-80-4651
17. INFORMANT'S OWN SIGNATURE George Strellner ADDRESS Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5770

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Myocardial insuf.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/12, 1939, to 9/8, 1969, that I last saw the deceased alive on 9/8, 1969, and that death occurred at 10:55 A.M., from the causes and on the date stated above.

23a. SIGNATURE Donna Thomas (Degree or title) MD
23b. ADDRESS 305 Fort St Boise
23c. DATE SIGNED 9/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 9-11-69
24c. NAME OF CEMETERY OR CREMATORY Meridian Cemetery
24d. LOCATION (City, town, or county) Meridian, Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 16, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Jack L. Green
LICENSE NO. E-528
FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3971
Local Reg. No. 594
Reg. Dist. No. 370

BIRTH NO.

SEP 18 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 011 Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; LENGTH OF STAY (In this place) 14 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 145 W. Idaho---At Home 000	d. STREET ADDRESS (If rural, give location) 145 West Idaho Street

3. NAME OF DECEASED (Type or Print) a. (First) ALVIN	b. (Middle) A.	c. (Last) LOWE	4. DATE OF DEATH (Month) Sept. (Day) 9 (Year) 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 18, 1885	9. AGE (In years last birthday) 84; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logging 17	10b. KIND OF BUSINESS OR INDUSTRY Lumber	11. BIRTHPLACE (State or foreign country) New Canada, Nova Scotia	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lowe	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-07-5384	17. INFORMANT'S OWN SIGNATURE 145 W. Idaho x Mrs Florence R Lowe	ADDRESS Boise, Ida.	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Thrombosis.	Brief.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)	Severe Chest Pains.	Brief.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19 , that I last saw the deceased alive on* *, 19 and that death occurred at* 615A *m., from the causes and on the date stated above.*

23a. SIGNATURE 583 E. D. Pans (Degree or title) Coroner	23b. ADDRESS 3720 Meadow Drive, Boise.	23c. DATE SIGNED 9-9-69.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 12, '69	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery	24d. LOCATION (City, town, or county) Boise Ada (State) Idaho
DATE REC'D BY LOCAL REG. Sept. 17 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Gary A. Cowger	LICENSE NO. E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 30 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3972
Local Reg. No. 585
Reg. Dist. No. 370

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada SEP 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1917 Kerr St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Selma	Louise	Rund	Sept. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Sept. 3, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Emery, Wisconsin	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lauritz Himo Olson	Norway	Sanna Kaldahl	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	544-28-7909	Mrs. Lloyd J. Yates	615 Elgert, Boise Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

2509

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitis — 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized — 20 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
[illegible] m.		

22. *I hereby certify that I attended the deceased from* April, 1960, *to* 9 Sept, 1969, *that I last saw the deceased alive on* 8 Sept, 1969, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clayton C. Morgan	370 M.D	Boise Idaho	11 Sept 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/13/1969	Syringa Gardens Cem.	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 12, 1969	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3973
Local Reg. No. 580
Reg. Dist. No. 370

BIRTH NO.

*E. Jones Jr.

SEP 12 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada (011)	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Canada (52) b. COUNTY: Ontario (555)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): in transit	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Breslan
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital (003)	d. STREET ADDRESS (If rural, give location): (no Street Number)

3. NAME OF DECEASED (Type or Print) a. (First): IDA	b. (Middle): —	c. (Last): Shantz	4. DATE OF DEATH (Month) (Day) (Year): Sept. 9, 1969		
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: April 6, 1895	9. AGE (In years last birthday): 74	IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (01)	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Canada	12. CITIZEN OF WHAT COUNTRY? Canada		
13. FATHER'S NAME: Noah C. Bechtel	BIRTHPLACE: Canada	14. MOTHER'S MAIDEN NAME: Mary Snyder	BIRTHPLACE: Canada		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): —	16. SOCIAL SECURITY NO.: none	17. INFORMANT'S OWN SIGNATURE: X John Henry Shantz	ADDRESS: Ontario Canada	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4444

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pulmonary Emboli

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Peripheral phlebothrombosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Dead on Arrival at Hosp.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Everett N. Jones Jr. (267) (Degree or title)	23b. ADDRESS	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal (3)	24b. DATE: 9-11-1969	24c. NAME OF CEMETERY OR CREMATORY: Mennonite Cemetery	24d. LOCATION (City, town, or county) (State): Kitchener Canada
DATE REC'D BY LOCAL REG.: Sept. 12, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Clyde J. Vassar	LICENSE NO.: E - 535

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 2 1969
SEP 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital

State File No. 3974
Local Reg. No. 111
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA SEP 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 31 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 2921 NORTH 36TH.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	P.	ZIMMERMAN	SEPTEMBER 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	FEBRUARY 22, 1920	49	--- / ---	--- / ---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ACCOUNTING	SAME	AMERICAN FALLS, IDAHO	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
ADAM ZIMMERMAN	RITZFIELD, WASHINGTON	BARBARA ISNER	RITZFIELD, WASHINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII	519-14-82-37	James A. Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Traumatic paraplegia after fracture of 957X dorsal spine	3 weeks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute pulmonary embolism	1 day
DUE TO (c)	Chronic urinary tract infection	3 weeks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE XX / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
2	VAH, Boise 13	Boise ADA Ada Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
VA 8-11-69 3:45am.		Jumped from window on 2nd floor into window well two stories beneath

22. XXXXXXXXXXXXXXXX attended the deceased from AUGUST 9, 19 69, to SEPTEMBER 9, 19 69 XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX

6 - ① Vet

SEP 16 1969,
FEB 18 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED SEP 18 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3975
Local Reg. No. 596
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Rural
d. STREET ADDRESS (If rural, give location) Rt. 4

3. NAME OF DECEASED (Type or Print) a. (First) Ruby b. (Middle) S. c. (Last) Mittleider

4. DATE OF DEATH (Month) (Day) (Year) Sept. 10. 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 20, 1897
9. AGE (In years last birthday) 72 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Manti, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Oliver Squire BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Nettie Andreason BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE John Mittleider ADDRESS Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

582X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic Nephritis

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute & Sub Acute
DUE TO (c) Glom. Nephritis.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 9-8-69
19b. MAJOR FINDINGS OF OPERATION Kidney biopsy
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8:26, 1969, *to* 9:10, 1969, *that I last saw the deceased alive on* 9-10, 1969, *and that death occurred at* 6:35P *m., from the causes and on the date stated above.*

23a. SIGNATURE Joan Thomas 528 (Degree or title)
23b. ADDRESS 305 Fort St Boise
23c. DATE SIGNED 9/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-15-69
24c. NAME OF CEMETERY OR CREMATORY Cloverdale
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. Sept. 18 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Jack H. Green
LICENSE NO. E-528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3976
Local Reg. No. 113
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 — SEP 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place): 5 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: CANYON 14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 115 - 14TH AVENUE NORTH

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HAWLEY	R.	WOODWARD	SEPTEMBER 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	DIVORCED	SEPT. 5, 1910	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN 24	AUTOMOBILE TIRE CO.	IDAHO	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
THOMAS WOODWARD	MISSOURI	LAVENIA SENTER	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII	519-16-6051	Conrad Senter	VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5710

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Alcoholic cirrhosis with — INTERVAL BETWEEN ONSET AND DEATH: several years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hepatic coma — 1 day
DUE TO (c) Drug addiction (narcotics, tranquilizers) for years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from SEPTEMBER 5, 1969, to SEPTEMBER 10, 1969 and that death occurred at 2:15a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. G. RIML, M.D.	VA CENTER, BOISE, IDAHO	9/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-12-69	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 15 1969	Myrtle Palmer	Glen G Siren	E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 17 1969 Bureau of Vital Statistics

State File No. 3977
Local Reg. No. 654
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print): a. (First) Leona b. (Middle) E. c. (Last) Bales

4. DATE OF DEATH (Month) (Day) (Year): Sept. 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 30, 1878
9. AGE (In years last birthday): 90 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): London, Kentucky
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Perry Evans — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Levina K. Jones — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mayme Ellen Green — ADDRESS: R#2 Meridian, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1530

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonitis secondary to Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Several days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) A cecum c̄ probable metastasis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic CV disease

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: J. A. Haney 216 (Degree or title)
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 9-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-13-69
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Oct. 15, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo. Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 11 1969

JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3978
Local Reg. No. 612
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA SEP 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 2 WEEKS
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ADA COUNTY NURSING HOME

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 3101 Malad St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDITH		EVERHART	SEPTEMBER 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	WIDOWED	JULY 27, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Hayward, So. Dakota	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walters	no record	Aikens	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519 16 1996A	X Mrs Orabell Brown	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4123 ASHD - cong. heart failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8/31 1969, to 9/11, 1969, that I last saw the deceased alive on 9/11, 1969, and that death occurred at 4:26 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	[signature]	9/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 15, 1969	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 24, 1969	Myrtle Palmer	Conway Grant	E 478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3979
Local Reg. No. 595
Reg. Dist. No. 370

BIRTH NO.

SEP 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: 011 Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — c. LENGTH OF: 25 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 2301 North 36th Street

3. NAME OF DECEASED (Type or Print)	a. (First) LAURA	b. (Middle) M.	c. (Last) SCHAEFER	4. DATE OF DEATH (Month) (Day) (Year) Sept. 11, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Oct. 2, 1891	9. AGE (In years last birthday): 77 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Goodland, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Zadac Franklin Antrim	BIRTHPLACE: Iowa	14. MOTHER'S MAIDEN NAME: Caroline North Clark	BIRTHPLACE: Kansas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 518-09-3647	17. INFORMANT'S OWN SIGNATURE: Florence C. Randolph	ADDRESS: 2301 N. 36th Boise, Ida.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5900

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Chronic Pyelonephritis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.: Generalized Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 12, 1967, *to* Sept 11, 1969, *that I last saw the deceased alive on* Sept 10, 1969, *and that death occurred at* 4:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 333 (Degree or title)	23b. ADDRESS: 808 Lalassia Dr. Boise	23c. DATE SIGNED: 9/15/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-13-69	24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery	24d. LOCATION (City, town, or county) (State): Meridian, Idaho
DATE REC'D BY LOCAL REG.: Sept. 17 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: [signature]	LICENSE NO.: E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED SEP 23 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3980
Local Reg. No. 605
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 3 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 2709 Annette St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DOROTHY	IRENE	ALLEN	Sept. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
Female	White	Married	May 27, 1924	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry J. Dieckman	Missouri	Cynthia L. Walker	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Harold A. Allen, Boise	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) BREAST CANCER — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-25, 1969, *to* 9-12, 1969, *that I last saw the deceased alive on* 9-12, 1969, *and that death occurred at* 9 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M M Rubinholder, M.D. 071		848 La Cassia, Boise	9/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	9/15/69	Dry Creek Cemetery	Boise,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 23, 1969	Myrtle Palmer	G. W. Waters G W Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

FEB 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 26 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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(4. Cert Copies) 115 NS

Certificate of Death
STATE OF IDAHO

State File No. 3981
Local Reg. No. 589
Reg. Dist. No. 370

BIRTH NO. Dr. Blickenstaff

RECEIVED
SEP 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 1 week	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glens Ferry, Ida.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus 003	d. STREET ADDRESS (If rural, give location) Box 34

3. NAME OF DECEASED (Type or Print)	a. (First) Bernard	b. (Middle) Joseph	c. (Last) Beaudry	4. DATE OF DEATH (Month) (Day) (Year) Sept. 12 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Jan. 5 1922	9. AGE (In years last birthday) 47 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor 01	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Quinnesec, Mich.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph J. Beaudry	BIRTHPLACE Canada	14. MOTHER'S MAIDEN NAME Edna Cristian	BIRTHPLACE Mich.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 2	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Mrs. R. Jennesse	ADDRESS Iron Mt. Mich.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Hemo-pneumo-thorax	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	multiple fractured ribs	
DUE TO (c)	Auto accident	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	① Delirium Tremens ② Dislocated hip ③ fractured pelvis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE — (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 06	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 8 69 m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Loren O. Blickenstaff (Degree or title) MD 183	23b. ADDRESS	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE Sept. 14 1969	24c. NAME OF CEMETERY OR CREMATORY Quinnesec	24d. LOCATION (City, town, or county) (State) Quinnesec Mich.
DATE REC'D BY LOCAL REG. Sept. 17, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER D. G. Gibson Gibson Funeral Home	LICENSE NO. 400

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 17 1969
JAN 5 1970
JAN 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 18 1969 Bureau of Vital Statistics

State File No. 3982
Local Reg. No. 597
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 5 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 022	d. STREET ADDRESS (If rural, give location): 5516 Targee Street

3. NAME OF DECEASED (Type or Print)	a. (First) ANNA	b. (Middle) M.	c. (Last) BOYLES	4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: March 6, 1929	9. AGE (In years last birthday): 40; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress 06	10b. KIND OF BUSINESS OR INDUSTRY: Restaurant	11. BIRTHPLACE (State or foreign country): Max, North Dakota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Andrew Broneske	BIRTHPLACE: Romania	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Romania	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 502-20-5607	17. INFORMANT'S OWN SIGNATURE: Edward M. Boyles	ADDRESS: 5516 Targee Boise, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cancer of Breast — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 30, 1969, *to* Sept 12, 1969, *that I last saw the deceased alive on* Sept. 12, 1969, *and that death occurred at* 6:26 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE: Maurice M. Rubinfeld MD 071 (Degree or title)	23b. ADDRESS: 848 La Cassia, Boise	23c. DATE SIGNED: 9-16-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-15-69	24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Sept. 18 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Robert G. Ross	LICENSE NO.: E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 3983
Local Reg. No. 112
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA — CITY: SEP 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place): 32 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO — b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1221 GRAND AVENUE

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: V.A.HOSPITAL, BOISE, IDAHO

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLARENCE	E.	DICKERSON	SEPT. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	WIDOWED	OCT. 25, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED LOGGER	LOGGING	KELLERTON, IOWA	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
FRANKLIN DICKERSON	IND.	ANNA GUYMAN	IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE	ADDRESS
YES	WWI	540 12 03 88	[signature]	V.A.HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Lobar pneumonia	4 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Carcinoma, left lung, bronchogenic	30 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. V.A. attended the deceased from Aug. 7, 19 69, to Sept. 12, 19 69 and that death occurred at 3:25P m., from the causes and on the date stated above.

23a. SIGNATURE (Type or print)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis, M.D. ROBERT C. LEWIS, M.D. 697	V.A.HOSPITAL, BOISE, IDAHO	9-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-15-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 16, 1969	Myrtle Palmer	[signature]	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

1 d c Vet

SEP 1 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3984
Local Reg. No. 114
Reg. Dist. No. 371

BIRTH NO.

RECEIVED

SEP 18 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: ADA 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: WASHINGTON 48 b. COUNTY: ASOTIN 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE	c. LENGTH OF STAY (In this place): 15 DAYS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CLARKSTON	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO 004	d. STREET ADDRESS (If rural, give location): 1105 COLLEGE COURT

3. NAME OF DECEASED (Type or Print) a. (First): ERNEST	b. (Middle): WAYNE	c. (Last): LEWIS	4. DATE OF DEATH (Month) (Day) (Year): SEPTEMBER 12, 1969	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED	8. DATE OF BIRTH: JANUARY 1, 1918	9. AGE (In years last birthday): 51 — IF UNDER 1 YR. Months: — Days: — IF UNDER 24 HRS. Hours: — Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOCIAL WORKER 08	10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVERNMENT	11. BIRTHPLACE (State or foreign country): CLATSKANIE, OREGON	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: OACAR LEWIS	BIRTHPLACE: MINNESOTA	14. MOTHER'S MAIDEN NAME: CAROLINE LARSON	BIRTHPLACE: NORWAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII 4	16. SOCIAL SECURITY NO.: 541-12-31-89	17. INFORMANT'S OWN SIGNATURE: James D. Bentley	ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO	

1519

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): extensive metastasis — 1/2 yr.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. VA attended the deceased from AUGUST 29, 1969, to SEPTEMBER 12, 1969, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE: O. G. RIML, M.D. 547 (Degree or title)	23b. ADDRESS: VA CENTER, BOISE, IDAHO	23c. DATE SIGNED: 9-15-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 9-13-69	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State): Clarkston, Washington
DATE REC'D BY LOCAL REG.: Sept. 17 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: [signature] FIRM NAME: SUMMERS FUNERAL HOME	LICENSE NO.: E-410

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 22 1969
OCT 16 1969
AUG 21 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3985
Local Reg. No. 118
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 SEP 18 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13 b. COUNTY Clearwater 150

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) Min.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Exchange Highway 80 OTD

d. STREET ADDRESS (If rural, give location) 429 Brown Street

3. NAME OF DECEASED (Type or Print) a. (First) Mildred b. (Middle) J c. (Last) Olson

4. DATE OF DEATH (Month) (Day) (Year) 9 - 12 - 69

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH Feb. 15, 1948

9. AGE (In years last birthday) 21 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) beautician 21

10b. KIND OF BUSINESS OR INDUSTRY beauty salon

11. BIRTHPLACE (State or foreign country) Orofino, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Emon A. Olson BIRTHPLACE Orofino, Idaho

14. MOTHER'S MAIDEN NAME Gladys Egly BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE X Emon A. Olson ADDRESS Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiply Head Injury

INTERVAL BETWEEN ONSET AND DEATH Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) public highway 06

21c. (CITY, TOWN, OR TOWNSHIP) Boise 011 (COUNTY) Ada (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 12, 69 1:00a m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? auto accident

22. I hereby certify that I attended the deceased from Did not see alive, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 1245 A m., from the causes and on the date stated above.

23a. SIGNATURE E D Paris 583 Coroner (Degree or title)

23b. ADDRESS 3720 Meadow Dr Boise

23c. DATE SIGNED 9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial Removal 3

24b. DATE Sept. 16, 69

24c. NAME OF CEMETERY OR CREMATORY Riverside

24d. LOCATION (City, town, or county) (State) Orofino, Clearwater, Idaho

DATE REC'D BY LOCAL REG. Sept. 17, 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Clyde J. Vassar

LICENSE NO. E-535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 24 1969

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3986
Local Reg. No. 115
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada
SEP 1 8 1969
Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gem 230

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

c. LENGTH OF STAY (in this place)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Exchange Hiway 80 cor

d. STREET ADDRESS (If rural, give location) Mounted Route Box 193

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
David	Ray	Riley	Sept. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	nevermarried	Sept. 16, 1948	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
serviceman E5	USMarines	Ainseworth, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theodore Riley	Crookston, Nebraska	Martha Dobson	Southerland, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes 1965-1969	519 54 6935	Theodore R. Riley	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Broken Neck, multiple Head Injury — INTERVAL BETWEEN ONSET AND DEATH: First?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	06	13011

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		Auto Rollover

22. *I hereby certify that I attended the deceased from* Did not see alive *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 1245 Hrs., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paris 583	Coroner	3720 Meadow Dr	9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial Removal	Sept. 18, 1969	Emmett Cemetery	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 17 1969	Myrtle Palmer	Clyde I. Vassar	E-535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 25 1969

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3987
Local Reg. No. 116
Reg. Dist. No. 371

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada SEP 1 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Franklin Exchange Hiway 80 ooo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Route 1 Box 337F

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	David	Rivers	September 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	never married	Dec. 12, 1948	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 47	lumber	Lexington, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Alfred Rivers	Odessa, Missouri	Nancy C. Cross	Lexington, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes 1966-1969	518 54 7909	Donald L Edwards	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	8169 Broken Neck, Smultiple Head Injuries	Inst-
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident 1	06	13 01

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		Auto Rollover

22. *I hereby certify that I attended the deceased from* Did not See Alive 19 16 , 19 , *that I last saw the deceased alive on* , 19 , *and that death occurred at* 1245 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Doris Brown SRN	3720 Meadow Dr Boise	9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3 Removal	Sept. 17, 1969	Emmett Cemetery	Emmett Idaho

DATE RECEIVED BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 17 1969	Myrtle Palmer	Clyde I. Vassar	E-535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 25 1969
OCT 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. NOV 17 1969
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 3988
Local Reg. No. 117
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 SEP 1 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (In this place) Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Exchange Highway 80 502

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 351
a. STATE Idaho
b. COUNTY Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 3630 - 17th Street

3. NAME OF DECEASED (Type or Print) a. (First) Jennifer b. (Middle) Irene c. (Last) Tarbert
4. DATE OF DEATH (Month) (Day) (Year) 9-12-69
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH 16 April 1948
9. AGE (In years last birthday) 21
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY College
11. BIRTHPLACE (State or foreign country) Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Bruce Tarbert
BIRTHPLACE Deer Park, Wn.
14. MOTHER'S MAIDEN NAME Irene Martin
BIRTHPLACE Southwick, Ida.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 58 4601
17. INFORMANT'S OWN SIGNATURE Bruce A. Tarbert
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiple Head Injury
INTERVAL BETWEEN ONSET AND DEATH Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13011
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Auto Road Accident

22. I hereby certify that I attended the deceased from Did not see, 19 alive, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1245 P m., from the causes and on the date stated above.

23a. SIGNATURE Ed Paris (Degree or title) Coroner 583
23b. ADDRESS 3720 Meadow Dr Boise
23c. DATE SIGNED 9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial 3
24b. DATE Burial 15 Sept 1969
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho (NezPerce Co.)

DATE REC'D BY LOCAL REG. Sept. 17, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Clyde J. Vassar
LICENSE NO. E-535
FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DR-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 22 1969

DEC 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3989
Local Reg. No. 613
Reg. Dist. No. 370

BIRTH NO.

SEP 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 1 Year	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalecent Center 332	d. STREET ADDRESS (If rural, give location): 3402 Broadway

3. NAME OF DECEASED (Type or Print)	a. (First) ELMER	b. (Middle) MADISON	c. (Last) SEARL	4. DATE OF DEATH (Month) 9 (Day) 13 (Year) 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH: Nov. 14, 1879	9. AGE (In years last birthday): 89	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Retired) 04	10b. KIND OF BUSINESS OR INDUSTRY: Farmer	11. BIRTHPLACE (State or foreign country): Garnett, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: James Searl	BIRTHPLACE	14. MOTHER'S MAIDEN NAME: Osborn	BIRTHPLACE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-66-0496J	17. INFORMANT'S OWN SIGNATURE: X Mrs Ernest Lewandowski	ADDRESS		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis generalized
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 8, 1968, *to* Sept 13, 1969, *that I last saw the deceased alive on* Sept 13, 1969, *and that death occurred at* 7:00 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 333 (Degree or title)	23b. ADDRESS: 808 La Cama Dr Boise	23c. DATE SIGNED: 9-19-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 9-17-69	24c. NAME OF CEMETERY OR CREMATORY: Dayton Cemetery	24d. LOCATION (City, town, or county) (State): Dayton, Washington
DATE REC'D BY LOCAL REG.: Sept. 24, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Eldon T. Pearson	LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3990
Local Reg. No. 625
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 013

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: California 05
b. COUNTY: Los Angeles 535
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Van Nuys
d. STREET ADDRESS (If rural, give location): 16943 Bassett Street

3. NAME OF DECEASED (Type or Print): a. (First) THEODORE b. (Middle) J. c. (Last) STARKEY

4. DATE OF DEATH: (Month) Sept. (Day) 13, (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: July 20, 1939
9. AGE (In years last birthday): 30
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elvin Frank Starkey — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Virginia Hazel Bygee — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs Virginia H. Douglass — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5710

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hepatic cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: ? 1-2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) pos alcohol abuse
DUE TO (c) pos drug

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1968, *to* 13 Sept, 19 69, *that I last saw the deceased alive on* 13 Sept, 19 69, *and that death occurred at* 8:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] (Degree or title) MD
23b. ADDRESS: 6003 Overland, Boise, Ida.
23c. DATE SIGNED: 25 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-16-69
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Oct. 2 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson
LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3991
Local Reg. No. 607
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 25 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Few Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 7017 State

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Kelly	Sue	Wilcoxon	9	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Never Married	3/27/1961	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03		Salt Lake City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Wilcoxon	Georgia	Helene M McKeel	Buhl, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	None	x Henry H. Wilcoxon	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Head Injury

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Struck by Car
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Massive Cerebral Swelling

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): /

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 04

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9 - 12 - 69 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Struck by Car

22. *I hereby certify that I attended the deceased from* 9-12, 1969 *to* 9-13, 1969, *that I last saw the deceased alive on* 9-13, 1969 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A H Kruschwell 704	401 Idaho Street	9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-13-69	Dry Creek Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 25 1969	Myrtle Palmer	Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

SEP 25 1969

SEP 29 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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69-8736 RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 3992
Local Reg. No. 600
Reg. Dist. No. 370

BIRTH NO.

SEP 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place) 1 day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location) 3850 Sheringham Dr.

3. NAME OF DECEASED (Type or Print) a. (First) Alanna	b. (Middle) Christine	c. (Last) Craft	4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1969		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Sept. 13, 1969	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days 1; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02	10b. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (State or foreign country) Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert H. Craft	BIRTHPLACE Oregon	14. MOTHER'S MAIDEN NAME Margaret Bogard	BIRTHPLACE Idaho		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S OWN SIGNATURE X Robert H. Craft	ADDRESS 3850 Sheringham		

7769

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral anoxia — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature Twin Birth

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-13, 1969 *to* 9-14, 1969, *that I last saw the deceased alive on* 9-14, 1969, *and that death occurred at* 8:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Larry T Irvine Cont MD 5191 (Degree or title)	23b. ADDRESS 200 E Bannock St Boise	23c. DATE SIGNED 9-17-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 18, 69	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Sept. 19 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Lowell D. Somaray	LICENSE NO. E-509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3993
Local Reg. No. 588
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 17 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes Hospital 022	d. STREET ADDRESS (If rural, give location): 2601 W. Boise Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) Walter	c. (Last) Lottridge	4. DATE OF DEATH	(Month) Sept	(Day) 14 (Year) 69
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: June 3, 1905	9. AGE (In years last birthday): 64	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Federal Aviation Adm. 08	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Galesburg, Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: William McClellan	BIRTHPLACE: Ohio	14. MOTHER'S MAIDEN NAME: Ruehama Erwin	BIRTHPLACE: Ohio			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes	(If yes, give war or dates of service): 1928---- 1934 8	16. SOCIAL SECURITY NO.: 333-09-5225	17. INFORMANT'S OWN SIGNATURE: X Mrs William Lattridge	ADDRESS: Boise		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cancer of Prostate with widespread metastases

INTERVAL BETWEEN ONSET AND DEATH: 3+ yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 3-27-68	19b. MAJOR FINDINGS OF OPERATION: Cancer of prostate	20. AUTOPSY? Yes ☑ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 21, 1968, *to* death, 19____, *that I last saw the deceased alive on* Sept 14, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: FB Jeppesen (Degree or title) 259. MD	23b. ADDRESS: Boise Idaho	23c. DATE SIGNED: 9/15/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-16-69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho		
DATE REC'D BY LOCAL REG.: Sept. 15 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Erle B. Byram
LICENSE NO.: E-533		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 17 1969

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

BIRTH NO SEP 2 4 1969

Certificate of Death
STATE OF IDAHO

State File No. 3994
Local Reg. No. 602
Reg. Dist. No. 370

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. County: Bureau of Vital Statistics Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 18 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1403 South Arcadia Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1403 South Arcadia Street

3. NAME OF DECEASED (Type or Print): a. (First) COLLEEN b. (Middle) M. c. (Last) MARRS

4. DATE OF DEATH (Month) (Day) (Year): Sept. 16, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 19, 1929

9. AGE (In years last birthday): 40

IF UNDER 1 YR. Months / Days

IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Food Processor-

10b. KIND OF BUSINESS OR INDUSTRY: Clover Club Foods

11. BIRTHPLACE (State or foreign country): Arco, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jack L. Moore BIRTHPLACE: Challis, Idaho

14. MOTHER'S MAIDEN NAME: Vera Nichols BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 564-36-5171

17. INFORMANT'S OWN SIGNATURE: Donald Marrs ADDRESS: 1403 S. Arcadia Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Short

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-18, 1969, to 9-16, 1969, that I last saw the deceased alive on 9-16, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE: Donald Marrs 318 (Degree or title): MD

23b. ADDRESS: 40 NO Oakland

23c. DATE SIGNED: 9/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-19-69

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Sept. 22 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Casey A. Summers

LICENSE NO.: E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

APR 15 1970
JUN 22 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 20 1979
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. OCT 5 1979
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

MAR 30 1990

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3995
Local Reg. No. 598
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 9 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3913 W. State Street

3. NAME OF DECEASED (Type or Print): a. (First) Bessie; b. (Middle) B.; c. (Last) Watson

4. DATE OF DEATH (Month) (Day) (Year): Sept. 16, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 6, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk 35

10b. KIND OF BUSINESS OR INDUSTRY: Drug Store

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Kerfoot
BIRTHPLACE: Virginia

14. MOTHER'S MAIDEN NAME: Jennie Buford
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-09-0141A

17. INFORMANT'S OWN SIGNATURE: x Virgil E Burke
ADDRESS: Seattle, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1829

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic Ca of Uterus — INTERVAL BETWEEN ONSET AND DEATH: 9 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 6, 19 69 *to* Sept. 16, 19 69 *, that I last saw the deceased alive on* Sept. 16, 19 69 *, and that death occurred at* 9:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE: George R Baker (Degree or title)

23b. ADDRESS: 121 E. Idaho St. Boise

23c. DATE SIGNED: 9/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: Sept. 22 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Robert G Lam

LICENSE NO.: E-497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

6 –

SEP 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 3996
Local Reg. No. 614
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1820 North 21th St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 1820 North 21th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Helen	Blackinger	Zapp	9	16	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Feb. 25, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	same	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Blackinger	Buffalo N.Y.	Helen Murphy	Calumet, Mich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-66-0984	X John S Zapp	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarct

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Faeuer's Cirrhosis
DUE TO (c) Metastatic Carcinoma of Breast

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Depression

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* MAR. 1969 *to* 5 Aug. 1969, *that I last saw the deceased alive on* 5 Aug. 1969 *and that death occurred at* 12:01 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert B. Montgomery	M.D.	2121 College Blvd.	9/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-19-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 25 1969	Myrtle Palmer	Elbert B. Gibson	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

OCT 6 1969
DEC 31 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

MAR 24 1970

DEC 19 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3997
Local Reg. No. 119
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 01 SEP 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place): 49 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL, BOISE, IDAHO 01 4

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1410 SHAW MOUNTAIN ROAD

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THOMAS	JEFFERSON	CANAVAN	SEPTEMBER 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	MAY 31, 1915	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TEACHER 12	BOISE COLLEGE	EAST ST. LOUIS, ILLINOIS	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
FRANK L. CANAVAN	ILLINOIS	MARY DONNELLY	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWII	332 07 44 20	Thomas Jefferson Canavan	VA HOSPITAL RECORDS, BOISE, IDAHO

1621

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 10 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from JULY 30, 1969, to SEPTEMBER 17, 1969 and that death occurred at 4:15a m., from the causes and on the date stated above.

23a. SIGNATURE, Degree or title	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis M.D. 547 ROBERT C. LEWIS, M.D.	VA CENTER, BOISE, IDAHO	9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-20- 1969	Morris Hill Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22 1969	Myrtle Palmer	E. B. Byram Ole B Byram	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 29 1969

MAR 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 3 1970

SEP 15 1989

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3998
Local Reg. No. 603
Reg. Dist. No. 370

BIRTH NO.

SEP 24 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY ~~Ada~~ Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1009½ Main St. 000	d. STREET ADDRESS (If rural, give location) 1009½ Main St.

3. NAME OF DECEASED (Type or Print) a. (First) Rudolph	b. (Middle)	c. (Last) Martinez	4. DATE OF DEATH (Month) (Day) (Year) Sept. 17, 1969		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH Mar. 23, 1895	9. AGE (In years last birthday) 74	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Mexico	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown	BIRTHPLACE Unknown		14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 524-05-2087		17. INFORMANT'S OWN SIGNATURE [signature]	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7824

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* on 9-17-69, 19__ to _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 10:00AM *from the causes and on the date stated above.* Cleveland time

23a. SIGNATURE [signature] 588 5 (Degree or title)	23b. ADDRESS 105 Ada County Courthouse Boise Idaho	23c. DATE SIGNED 9-19-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/19/69	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park	24d. LOCATION (City, town, or county) Boise, (State) Idaho
DATE REC'D BY LOCAL REG. Sept. 22, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Clyde J. Vassar	LICENSE NO. E535

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 9 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3999
Local Reg. No. 626
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 OCT 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 820 North 11th. Apt. 3 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 820 North 11th. Apt. 3

3. NAME OF DECEASED (Type or Print)
a. (First): Joseph
b. (Middle): Leonard
c. (Last): Mc Knight

4. DATE OF DEATH (Month) (Day) (Year): Sept. 17, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: July 24, 1901
9. AGE (In years last birthday): 68
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Drapery Business 07
10b. KIND OF BUSINESS OR INDUSTRY: Drapery
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: no record
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: no record
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): non
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: x [signature]
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See alive. *, 19____, that I last saw the deceased alive on ____, 19____ and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] .583 (Degree or title) Caroner
23b. ADDRESS: 3720 Meadow Dr. Boise
23c. DATE SIGNED: 9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-23-1969
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county): Boise Ada (State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 2, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E-478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

BIRTH NO. 69-8755

RECEIVED OCT 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4000
Local Reg. No. 637
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 305 North 14th

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): JEFFREY
c. (Last): SANDRUS

4. DATE OF DEATH (Month) (Day) (Year): Sept. 17, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Sept. 16, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days: 2; IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William L. Sandrus
BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Julie Varitek
BIRTHPLACE: Florida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: William L. Sandrus
ADDRESS: Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity & Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 36h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-16, 1969, *to* 9-17, 1969, *that I last saw the deceased alive on* 9/17, 1969, *and that death occurred at* 8 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl M. [illegible] 364 MD
23b. ADDRESS: 848 [illegible]
23c. DATE SIGNED: 10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/20/69
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Oct. 9 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [illegible]
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

DUTIES: OCT 20 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
OCT 1 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4001
Local Reg. No. 620
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 20 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 211- N. 22nd. St. 80

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 211 N. 22nd. Street

3. NAME OF DECEASED (Type or Print)
a. (First): Earle
b. (Middle): C
c. (Last): Craig

4. DATE OF DEATH (Month) (Day) (Year): Sep't. 18, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3/12/99
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil service 68
10b. KIND OF BUSINESS OR INDUSTRY: Veteran's Admin.
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harry Craig — BIRTHPLACE: California
14. MOTHER'S MAIDEN NAME: Ethel Kingman — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW # 1 3
16. SOCIAL SECURITY NO.: 553-32-5059
17. INFORMANT'S OWN SIGNATURE: Earleene C. Weaver — ADDRESS: 1400 Leadville Ave. Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 31
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Boise 011 Ada Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-18-69 9:30 PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Gunshot (32 Pistol) wound in forehead

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Frank E. Chaffant Jr. 5885 Justice of the Peace
23b. ADDRESS: Rm. 105 Ada County Courthouse Boise, Idaho
23c. DATE SIGNED: 9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 9/23/69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Crematory
24d. LOCATION (City, town, or county) (State): Boise

DATE REC'D BY LOCAL REG.: Sept. 25, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Andrew P. Dunbowske
LICENSE NO.: E-527

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Mountain View Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 29 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED Certificate of Death
STATE OF IDAHO

State File No. 4002
Local Reg. No. 604
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada — SEP 2 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restfull Manor Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 204 W. Franklin

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	F.	Falen	Sept. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 24, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Helena, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank H. Falen	Montana	Clara V. Hamuons	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	544-10-5011A	Donald Falen	

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 792X UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 3yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 6, 1953, *to* Sept 18, 1969, *that I last saw the deceased alive on* Sept 17, 1969, *and that death occurred at* 2 05 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Maurice W. Rudolph Coroner	848 La Cassia Drive	9/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 22, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22, 1969	Myrtle Palmer	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 30 1969

Bureau of Vital Statistics

State File No. 4003
Local Reg. No. 123
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
STAY (In this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: V.A.Hospital, Boise, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROBERT	W.	FLEMING	SEPT. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	7-5 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Farming	Ellensburg, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Fleming	Glasgow, Scotland	Elizabeth Gilkey	Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI	518 12 83 58	[illegible]	V.A.HOSPITAL RECORDS, BOISE, IDAHO

4409

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Generalized atherosclerosis	several years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Bronchopneumonia	12 days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I attended the deceased from Sept. 9, 1969, to Sept. 18, 1969, that I last saw the deceased alive and that death occurred at 9:05 P.M., from the causes and on the date stated above.

V.A.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. RIML, M.D. 597	VAC, BOISE, IDAHO	9/1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-20-69	Morris Hill	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 24, 1969	Myrtle Palmer	Conway & Grant	13478

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4004
Local Reg. No. 124
Reg. Dist. No. 371

RECEIVED SEP 30 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 24 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO b. COUNTY: CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): ROUTE #2

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): V.A.HOSPITAL, BOISE, IDAHO

3. NAME OF DECEASED (Type or Print): a. (First) JOSEPH b. (Middle) P. c. (Last) MARSH

4. DATE OF DEATH (Month) (Day) (Year): SEPT. 19, 1969

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: SEPT.24,1894
9. AGE (In years last birthday): 74
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Boilermaker
10b. KIND OF BUSINESS OR INDUSTRY: Boilermaker
11. BIRTHPLACE (State or foreign country): SARGENT,NEBR.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM J. MARSH BIRTHPLACE: PA.
14. MOTHER'S MAIDEN NAME: OLIVE GIBSON BIRTHPLACE: DEMOINES,IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 545 03 28 75
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: V.A.HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchogenic cancer — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: V.A.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I attended the deceased from Aug. 26, 1969, to Sept. 19, 1969, that death occurred at 1:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE: O.RIML,M.D. (Degree or title)
23b. ADDRESS: VAC,BOISE,IDAHO
23c. DATE SIGNED: 9-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/22/69
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: Sept.29 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-447
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4005
Local Reg. No. 120
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA SEP 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) V.A.HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 819 Fairview

3. NAME OF DECEASED (Type or Print) a. (First) IKE b. (Middle) J. c. (Last) PARIS

4. DATE OF DEATH (Month) (Day) (Year) SEPT. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	OCT. 7, 1898	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED RAILROAD EMPLOYEE	RAILROAD	BOISE, IDAHO	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
ISAAC PARIS	MO.	NELLIE MURPHY	IDAHO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII	518 18 7013A	[signature]	V.A.HOSPITAL RECORDS, BOISE, IDAHO

880X

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bilateral adrenal hemorrhage	3 Days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hip pinning for fracture	10 Days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pneumonia, right lower lung	3 Days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-9-69	Trochanteric fracture right hip	Yes XX No

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
1	In or about home 01	Nampa 142 Canyon Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
VA	9-6-69		m.		Fell while descending back door steps at home

22. [illegible] attended the deceased from Sept. 6, 19 69, to Sept. 19, 19 69 [illegible] and that death occurred at 4 a. m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Wm. W. Laxson 541 W. W. LAXSON, M.D. (Degree or title)	VAC, BOISE, IDAHO	9-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	9/22/69	Cloverdale Memorial Park	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 23, 1969	Myrtle Palmer	G. W. Waters [signature]	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual resid[illegible]

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4006
Local Reg. No. 670
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada SEP 26 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 9 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2106 N. 20th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	Edward	Rogers	Sept. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 16, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Bus Driver		Buffalo, New York	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Rogers	U.S.	Naomi Crane	U.S.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-07-1520	x Mrs. George Rogers	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	425 W Bannock	9/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/23/69	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 26 1969	Myrtle Talmer	C. E. Alden	299

FIRM NAME: Alden-Waggoner

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 3 1971 SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
SEP 26 1969
Bureau of Vital

Certificate of Death
STATE OF IDAHO

State File No. 4007
Local Reg. No. 611
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 204 N. Atlantic 000	d. STREET ADDRESS (If rural, give location): 204 N. Atlantic

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) Jane	c. (Last) Collins	4. DATE OF DEATH (Month) (Day) (Year) Sept. 20, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Nov. 29, 1909	9. AGE (In years last birthday): 59; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 51	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Bethany, Oregon	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Michael Fitzsimmon	BIRTHPLACE: Ireland	14. MOTHER'S MAIDEN NAME: Mary Jane Nolan	BIRTHPLACE: Wisconsin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-70-1348	17. INFORMANT'S OWN SIGNATURE: Horace H. Collins	ADDRESS: 204 N. Atlantic Boise	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute cardiac arrhythmia	—
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arterio sclerotic heart disease	6 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 9-17, 1969, *to* 9-20, 1969, *that I last saw the deceased alive on* 9-17-, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: W D Forney 173 (Degree or title) MD	23b. ADDRESS: 425 Bannock	23c. DATE SIGNED: 9-23-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-24-69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Sept. 26 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: A. E. Alden	LICENSE NO.: E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 26 1969
OCT 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4008
Local Reg. No. 121
Reg. Dist. No. 371

BIRTH NO.

SEP 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: ADA	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: WASHINGTON 48 b. COUNTY: OKANOGAN 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE; c. LENGTH OF STAY (In this place): 2 DAYS	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): OKANOGAN
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO	d. STREET ADDRESS (If rural, give location): BOX 121

3. NAME OF DECEASED (Type or Print) a. (First): ELMER	b. (Middle): E.	c. (Last): SMITH	4. DATE OF DEATH (Month) (Day) (Year): SEPTEMBER 20, 1969	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED	8. DATE OF BIRTH: AUG. 26, 1920	9. AGE (In years last birthday): 49; IF UNDER 1 YR. Months --, Days --; IF UNDER 24 HRS. Hours --, Min. --
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER	10b. KIND OF BUSINESS OR INDUSTRY: UNKNOWN	11. BIRTHPLACE (State or foreign country): MORROW CITY, OHIO	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: FRANK J. SMITH	BIRTHPLACE: MICHIGAN	14. MOTHER'S MAIDEN NAME: MARY ANN FEIGLEY	BIRTHPLACE: OHIO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII	16. SOCIAL SECURITY NO.: 296-12-2775	17. INFORMANT'S OWN SIGNATURE: James D. Bentley	ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO	

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac arrest	Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Anoxia	Sudden
DUE TO (c)	Pulmonary emphysema	Long-Standing
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 9-18-69	19b. MAJOR FINDINGS OF OPERATION: Bulleus emphysema right lung.	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. I ~~[illegible]~~ VA attended the deceased from SEPTEMBER 18, 1969, to SEPTEMBER 20, 1969 ~~that I last saw the deceased alive on [illegible]~~, and that death occurred at 5:55 p.m., from the causes and on the date stated above.

23a. SIGNATURE: RAYMOND J. BUNGARD, M.D. (Degree or title)	23b. ADDRESS: VA CENTER, BOISE, IDAHO	23c. DATE SIGNED: 9-22-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 9/22/69	24c. NAME OF CEMETERY OR CREMATORY: Rivercliff Cemetery	24d. LOCATION (City, town, or county) (State): Mt. Gilead, Ohio
DATE REC'D BY LOCAL REG.: Sept. 23, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: G. W. Waters	LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969
SEP 30 1969
JUL 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4009
Local Reg. No. 122
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: ADA	SEP 26 1969		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: OREGON 38	b. COUNTY: UNION 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE	c. LENGTH OF STAY (In this place): 39 DAYS		b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LA GRANDE	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO			d. STREET ADDRESS (If rural, give location): FOLEY HOTEL	

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	NMI	MILLER	SEPTEMBER 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	NEVER MARRIED	APRIL 1, 1890	79	-- / --	-- / --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
WATCHMAN 17	SAW MILL	NORTH CAROLINA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
CHARLES MILLER	NORTH CAROLINA	THELIA MC COY	FLORIDA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI 3	541-32-75-76	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/24

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic cardiovascular disease with congestive heart failure and cerebral arteriosclerosis. — INTERVAL BETWEEN ONSET AND DEATH: 16 years+

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Osteoarthritis. — 16 years +

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I, VA, attended the deceased from AUGUST 13, 1969, to SEPTEMBER 21, 1969, and that death occurred at 12:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis, M.D. 541 / ROBERT C. LEWIS, M.D.	VA CENTER, BOISE, IDAHO	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	9-25-69	Willamette Nat'l Cem.	Portland, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 26 1969	Myrtle Palmer	A. E. Alden	E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

1 U.9

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended December 17, 1969

Certificate of Death
STATE OF IDAHO

State File No. 4010
Local Reg. No. 622
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 18 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: At Home - 715 N. 17th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 715 North 17th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Leon	S.	Simpson	September 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Sept 29, 1877	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant 22	Automobile	Star, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William A. Simpson	New York	Dora Chase	New Jersey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No -----	518-07-4186	Dorathy McKelvey	404 Cashmere, Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chr. congestive Ht. failure — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility — 20 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-10, 19 60, *to* 6-21, 19 69, *that I last saw the deceased alive on* 9-19, 19 69, *and that death occurred at* 4:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Q. W. Mack, M.D. 319	Boise, Idaho	9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 24, 1969	Morris Hill Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 30, 1969	Myrtle Palmer	Gary A. Cowger	E 526

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Summers Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of Ada

Certificate No. 69- 4010

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for Leon S. Simpson (Name on Original Certificate) who died (Was Born or Died) on Sept 21, 1969 (Date of Event)

in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by family records (Bible Record, Insurance Policy, Etc.) located when probating estate prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	Sept 29, 1876	Sept 29, 1877
Age	92	91

Subscribed and sworn to before me this 18th day of December, 19 69

Notary Public, residing at Boise

My commission expires Sept 10, 1970

(Seal)

Signed Mrs. Dorothy McKelvey

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

404 cashmere Rd. Boise, Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 18th day of December, 19 69

Notary Public, residing at Boise

My commission expires Sept 10, 1970

(Seal)

Signed Dale M. Marshall

(Signature of Any Credible Person)

1205 W Bamback Boise, Idaho

(Street Address, City, State)

FORM DH 60-155

SUPERVISE CLERK
STATE OF IDAHO
SECRETARY
OF
PUBLIC

SUPERVISE CLERK
STATE OF IDAHO
SECRETARY
OF
PUBLIC

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4010
Local Reg. No. 622
Reg. Dist. No. 370

BIRTH NO.

OCT 3 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 18 Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home--715 N. 17th St.	d. STREET ADDRESS (If rural, give location): 715 North 17th Street

3. NAME OF DECEASED (Type or Print)	a. (First): LEON	b. (Middle): S.	c. (Last): SIMPSON	4. DATE OF DEATH (Month) (Day) (Year): Sept. 21 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Sept. 29, 1876	9. AGE (In years last birthday): 92; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant	10b. KIND OF BUSINESS OR INDUSTRY: Automobile	11. BIRTHPLACE (State or foreign country): Star, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William A. Simpson	BIRTHPLACE: New York	14. MOTHER'S MAIDEN NAME: Dora Chase	BIRTHPLACE: New Jersey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 518-07-4186	17. INFORMANT'S OWN SIGNATURE: Dorothy McKelvey	ADDRESS: 404 Cashmere Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Chr. Congestive Ht. failure	10 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Senility	20 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1960, *to* 9-21, 1969, *that I last saw the deceased alive on* 9-19, 1969, *and that death occurred at* 4:45p *m., from the causes and on the date stated above.*

23a. SIGNATURE: Qw Mack	(Degree or title): M.D.	23b. ADDRESS: Boise Idaho	23c. DATE SIGNED: 9-23-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 24, '69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cem.	24d. LOCATION (City, town, or county): Boise Ada (State): Idaho
DATE REC'D BY LOCAL REG.: Sept. 30, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Gary A. Cowger	LICENSE NO.: E-526

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 16 1969
DEC 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4011
Local Reg. No. 607
Reg. Dist. No. 370

BIRTH NO.

RECEIVED STATE OF IDAHO
SEP 24 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 822½ Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 822½ Main St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ODIS	L.	CABINESS	Sept. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Unknown	Oct. 17, 1923	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Disabled Veteran		Shelby Co, Alabama	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Clay Cabiness	Ala.	Maggie P. Miles	Ala.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
WWII	416-20-1682		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9803

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Sleeping pills, Alcohol, and Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See, to Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Do Paris 585 Coroner	3720 Meadow Drive, Boise.	9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	9/24/69	Houston, Texas	Houston Texas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 24, 1969	Myrtle Palmer	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4012
Local Reg. No. 616
Reg. Dist. No. 370

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 9 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7701 Ustick Road

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 7701 Ustick Road

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Frank	William	McCain	September 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	December 11, 1893	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Builder	Construction	Pepin, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel D. McCain	Wisconsin	Pauline Ficker	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518 30 6266	Mark H McCain	Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute myocardial infarction	5 minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary occlusion	10 minutes
DUE TO (c)	Arteriosclerotic heart disease	20 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Congestive heart failure	3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6 Dec 1964 *to* 22 Sept 1969, *that I last saw the deceased alive on* August 30, 1969, *and that death occurred at* 7:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clayton C Morgan 370	M.D.	Boise Idaho	25 Sept 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 25, 1969	Mt. View Cemetery	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29 1969	Myrtle Palmer	Glen G. Giren	E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 20 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4013
Local Reg. No. 615
Reg. Dist. No. 370

BIRTH NO.

SEP 30 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 01	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): Route #1, S. Bogart Lane

3. NAME OF DECEASED (Type or Print) a. (First): Jesse	b. (Middle):	c. (Last): Moren	4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Aug. 11, 1895	9. AGE (In years last birthday): 74 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: farming	11. BIRTHPLACE (State or foreign country): Decator County, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Joseph Moren	BIRTHPLACE: Illinois	14. MOTHER'S MAIDEN NAME: Menerva Holley	BIRTHPLACE: Illinois	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 521-32-3771	17. INFORMANT'S OWN SIGNATURE: X Dennis Moren	ADDRESS	

2059

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Granulocytic leukemia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Severe anemia
Severe thrombocytopenia.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/31, 1969, *to* 9/22, 1969, *that I last saw the deceased alive on* 9/21, 1969, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 095 M.D. (Degree or title)	23b. ADDRESS: Boise, Idaho	23c. DATE SIGNED: 9/23/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-24-1969	24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery	24d. LOCATION (City, town, or county) (State): Nampa, Idaho
DATE REC'D BY LOCAL REG.: Sept. 26, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Paul Waggoner	LICENSE NO.: #E-422

FIRM NAME: Alden Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

343-4281

State File No. 4014
Local Reg. No. 627
Reg. Dist. No. 270

STATE OF IDAHO

BIRTH NO.

RECEIVED
OCT 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN: Boise
d. STREET ADDRESS (If rural, give location): 211 E. 39th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Georgia	Bernice	Root	Sept. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Feb. 19, 1909	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Los Angeles, Calif.	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Kennedy	Iowa	Anna Pearson	Manor, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-28-1071	Glennys Root	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4309 Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Sept 21, 1969, *to* Sept 22, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 7:40 AM *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	401 Idaho St., Boise, Idaho	9/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/25/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 2, 1969	Myrtle Palmer	Earl Waggoner	E-822

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 18 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or, refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4015
Local Reg. No. 623
Reg. Dist. No. 370

BIRTH NO.

OCT 3 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): Few Min.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 2124 So. Hilton

3. NAME OF DECEASED (Type or Print) a. (First): JESSIE	b. (Middle): LORA	c. (Last): SUNDERWIRTH	4. DATE OF DEATH (Month) Sept. (Day) 22 (Year) 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Aug. 23, 1904	9. AGE (In years last birthday): 65 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse 13	10b. KIND OF BUSINESS OR INDUSTRY: Nursing	11. BIRTHPLACE (State or foreign country): Rockville, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Walter W. Durrand	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Effie J. Peeler	BIRTHPLACE: Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 520-09-7860	17. INFORMANT'S OWN SIGNATURE: X Ina Mae Harkin	ADDRESS: 11 N. Orchard Boise, Ida.	

8169

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Crushed Chest, Multiply Internal Injuries.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs;

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 06	21c. (CITY, TOWN, OR TOWNSHIP): Boise 010 (COUNTY): Ada (STATE): Idaho	
21d. TIME OF INJURY (Month) 9 (Day) 22 (Year) 69 (Hour) 430P m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR? One Car, Auto Accident. Hit Tree.	

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 840P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Harris, 583	(Degree or title): Coroner 3720	23b. ADDRESS: Meadow Drive, Boise.	23c. DATE SIGNED: 9-25-69.
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 27, '69	24c. NAME OF CEMETERY OR CREMATORY: Prairie City Cem.	24d. LOCATION (City, town, or county): Prairie City (State): Missouri
DATE REC'D BY LOCAL REG.: Sept. 30 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Dodwell W. Demaray	LICENSE NO.: #E-509

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1969

OCT 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4016
Local Reg. No. 632
Reg. Dist. No. 270

BIRTH NO.

RECEIVED
OCT 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2110 N. 9th St.

3. NAME OF DECEASED (Type or Print): a. (First) CLAUDE; b. (Middle) F.; c. (Last) Wallace

4. DATE OF DEATH: (Month) Sept. (Day) 23, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 2, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (State or foreign country): Tillamook Co, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Wallace
BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Estella Pollard
BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-16-7159

17. INFORMANT'S OWN SIGNATURE: X Corbin Wallace
ADDRESS: 2110 N 9th

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4410

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Dissecting aneurism of aorta — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — 10+ yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary heart disease — several yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-18, 1959, to 9-23, 1969, that I last saw the deceased alive on 9-23, 1969, and that death occurred at 1 P. m., from the causes and on the date stated above.

23a. SIGNATURE: Paul F. Misner M.D. (Coroner or Title)

23b. ADDRESS: 1333 W. Jefferson Boise, Idaho

23c. DATE SIGNED: 9/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/27/69

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park

24d. LOCATION (City, town, or county): Boise,
(State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 3, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: C. S. Vassar

LICENSE NO.: E-535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 - 1969

APR i 3 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4017
Local Reg. No. 621
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 2 1969 Bureau of Vital Stat

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 48 E. Carlton

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) H. c. (Last) Jorges

4. DATE OF DEATH (Month) (Day) (Year): Sept 24, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 21, 1906

9. AGE (In years last birthday): 62
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meter Reader
10b. KIND OF BUSINESS OR INDUSTRY: Idaho Power Co.

11. BIRTHPLACE (State or foreign country): Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Herman W. Jorges
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Ida Mae Puls
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 507-09-1989

17. INFORMANT'S OWN SIGNATURE: Jack A. Van Laeyen
ADDRESS: Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute posterion myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Coronary heart disease

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: few hrs / several yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-1, 1968, to 9-24, 1969, *that I last saw the deceased alive on* 9-24, 1969, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner (Degree or title) M.D.

23b. ADDRESS: 1333 W. Jefferson Boise, Idaho

23c. DATE SIGNED: 9/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-27-69

24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery

24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Oct. 2 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Leo Jarred

LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 - 1969

OCT 2 1969
SEP 2 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4018
Local Reg. No. 125
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA OCT 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
LENGTH OF STAY (In this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMIN. CENTER

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 1837 Rand St

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
OSCAR	M	MOE	Sept 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	2-13-13	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN	LUMBER	JAMESTOWN, NEW YORK	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
MARTIN MOE	NORWAY	ANNE MELBY	NORWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WW II	371 10 3025	D.L. MOORE	VA Center, Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchogenic carcinoma with metastases. Not known.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I, VA, attended the deceased from Sept. 12, 19 69, to Sept 25, 19 69 and that death occurred at 9:15P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F.B.HINE, M.D.	VA CENTER, BOISE, IDAHO	9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-29-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 30 1969	Myrtle Palmer		E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1969

OCT 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

APR 15 1970

SEP 18 1970

MAY 20 1971

AUG 18 1975

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4019
Local Reg. No. 638
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 21dy
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nyssa
d. STREET ADDRESS (If rural, give location): 720 N. 7th St

3. NAME OF DECEASED (Type or Print)
a. (First): Francisco
b. (Middle): P.
c. (Last): Vielma

4. DATE OF DEATH (Month) (Day) (Year): 9-25-1969

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1-3-1901
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maxico
12. CITIZEN OF WHAT COUNTRY? Mexico

13. FATHER'S NAME: Raymond Vielma — BIRTHPLACE: Mexico
14. MOTHER'S MAIDEN NAME: Felizitas Perz — BIRTHPLACE: Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 460-62-8258A
17. INFORMANT'S OWN SIGNATURE: Viola Vielma — ADDRESS: 720 N7th Nyssa Oregon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Anemia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Bleeding gastric carcinoma
DUE TO (c): Tumor

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Malnutrition

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Tumor of upper abdomen
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/29, 1969, *to* 9/25, 1969, *that I last saw the deceased alive on* 9/24, 1969, *and that death occurred at* 1:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 814 (Degree or title) MD
23b. ADDRESS: 2121 College Blvd. Boise Idaho
23c. DATE SIGNED: 10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-27-1969
24c. NAME OF CEMETERY OR CREMATORY: Nyssa
24d. LOCATION (City, town, or county) (State): Nyssa Oregon

DATE REC'D BY LOCAL REG.: Oct. 9 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. FUNERAL DIRECTOR: [signature] — ADDRESS: E-509 Summer Funeral Home

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 7 1969

Bureau of Vital Statistics

State File No. 4020
Local Reg. No. 634
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes 502

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 901 South Owyhee St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Theodore		Falk	9 26 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	July 19, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Department Store 22	same	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	Unknown	Ann Falk Loper	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic Ca Kidney — INTERVAL BETWEEN ONSET AND DEATH: 7yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1890

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* November, 1964, *to* 9-26, 1969, *that I last saw the deceased alive on* 9-26, 1969, *and that death occurred at* 3:53 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George R Bilen MD	121 East Idaho - Boise	9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-27-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 7 1969	Myrtle Palmer	Earle B. Bryson	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

OCT 7 1969
OCT 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4021
Local Reg. No. 629
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY: 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4122 West State Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RAYMOND	H.	RENO	Sept. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 11, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic-Welder	Same	Payden, Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry M. Reno	Illinois	Amanda R. Harold	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	518-05-9573	Emily M. Reno	4122 State ~~Boise~~, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 6 Yrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Emphysema — Years.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1963, *to* 9-26, 1969, *that I last saw the deceased alive on* 9-26-69, 19____, *and that death occurred at* 8:15 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. B. Gotterson MD	Boise	9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-30-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 2, 1969	Myrtle Palmer	Everett Demaray	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

3 -

OCT 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4022
Local Reg. No. 636
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (In this place): 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 119 Ave B.

3. NAME OF DECEASED (Type or Print): a. (First) Dorothy b. (Middle) F. c. (Last) Stewart

4. DATE OF DEATH: (Month) 9 (Day) 26 (Year) 69

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 7, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: same

11. BIRTHPLACE (State or foreign country): Roscommon, Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas P. Byrnes
BIRTHPLACE: Ireland

14. MOTHER'S MAIDEN NAME: Catherine Doylan
BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-54-0676

17. INFORMANT'S OWN SIGNATURE: Mrs Patricia H. Edwards
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auricular fibrillation — 1 week
DUE TO (c) Arteriosclerosis — 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1st 1969, to Sept 26, 1969, that I last saw the deceased alive on Sept 26, 1969, and that death occurred at 12:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE: Bruce B Ward MD (Degree or title)

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-29-69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Oct. 7 1969

REGISTRAR'S SIGNATURE: Myrtle Talmage

25. EMBALMER: Eric B Bryan

LICENSE NO.: E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4023
Local Reg. No. 128
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
OCT 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION: 4808 Alamosa St. 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4808 Alamosa St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Dewey	Upson	Sept. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Mar. 15, 1898	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farm	Sedgwick Co., Colo.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William G. Upson	Illinois	Jennie Ball	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 36 0034	X Ronald J. Booth	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 955X Self Inflicted Gun Shot thru Head. — Interval between onset and death: Instant.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
2 Suicide	31	13 011

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise,	9-29-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 29, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 9, 1969	Myrtle Palmer	[signature]	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 14 1970

NOV 12 1997

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4024
Local Reg. No. 126
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
OCT 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route #1 Box 312 Eagle, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle, Idaho
d. STREET ADDRESS (If rural, give location): Route #1 Box 312 Eagle, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Kenneth	Weldon	King	9	27	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	10 years old	June 8, 1959	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	Same	Worland, Wyo.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward King	Caldwell, Idaho	Mary K. Crowin	Wood River, Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	10 years old	X W. C. Sheldon	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Strangulation, by Rope. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Swinging on a dangleing Rope become entangled.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	34	13010

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* ____ 19____, *and that death occurred at* 240P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise.	9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-30-69	Star Cemetery	Star, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 1 1969	Myrtle Palmer	Edith B. Bryam	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 0 3 1999

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4025
Local Reg. No. 617
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 30 1969
Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho	b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place): 23 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: St. Lukes Hospital		d. STREET ADDRESS (If rural, give location): 814 North 10th Street	

3. NAME OF DECEASED (Type or Print)	a. (First) HILDEGARDE	b. (Middle) E.	c. (Last) MAYER	4. DATE OF DEATH (Month) (Day) (Year)	Sept. 27, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married	8. DATE OF BIRTH: Aug. 20, 1899	9. AGE (In years last birthday): 70	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher	10b. KIND OF BUSINESS OR INDUSTRY: Education	11. BIRTHPLACE (State or foreign country): Pittsburg, Penn.	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Michael Mayer	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Magdelina Ruesswig	BIRTHPLACE: Germany			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 519-05-7210	17. INFORMANT'S OWN SIGNATURE: Frieda L. Mayer	ADDRESS: Boise, Idaho 923½ Fort St.		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

517X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Respiratory Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Fibrosis & Emphysema — 20 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture Rt Hip — 2 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from August, 1958, to September 27, 1969, that I last saw the deceased alive on 27 September, 1969, and that death occurred at 2:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE: George R Baker (Degree or title) MD	23b. ADDRESS: 121 East Idaho - Boise	23c. DATE SIGNED: 9-30-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9-30-69	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Sept. 30, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Robert G. Lee	LICENSE NO.: E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 30 1969
MAY 19 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4026
Local Reg. No. 618
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2011 North 18th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JULIUS	D.	McDONALD	Sept. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 4, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher	Farming	Nampa, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James McDonald	Dublin, Ireland	Florence DeMyer	Fulton, Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	519-46-9687	X Beulah D. McDonald	Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Chronic lung disease (emphysema) — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: Blood dyscrasia — 2 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 April, 1968, *to* 27 Sept., 1969, *that I last saw the deceased alive on* 27 September, 1969, *and that death occurred at* 9:00 AM *from the causes and on the date stated above.*

23a. SIGNATURE: Lyle Stones, M.D. (Degree or title)
23b. ADDRESS: 220 North 1st Street, Boise, Idaho
23c. DATE SIGNED: 9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-30-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 30, 1969	Myrtle Palmer	Dale McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

2 - 104.

SEP 30 1969
JUL 14 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

BIRTH NO. OCT 3 1969

Certificate of Death
STATE OF IDAHO

State File No. 4027
Local Reg. No. 630
Reg. Dist. No. 370

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH — Bureau of Vital Statistics — Ada Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Boise Convalescent Center 321

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Ada Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 146 Willow Way Drive

3. NAME OF DECEASED (Type or Print): a. (First) NELL b. (Middle) c. (Last) MITCHELL
4. DATE OF DEATH (Month) (Day) (Year): Sept. 27, 1969
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 11, 1884
9. AGE (In years last birthday): 84
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): LaCygne, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Henry F. Tyler BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Betty BIRTHPLACE: Missouri
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Nina Wesler ADDRESS: 146 Willow Way Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4409 Toxemia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gangrene leg — 11
DUE TO (c) Arterio sclerosis — yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — 1960 *to* 9-27-69, 1969, *that I last saw the deceased alive on* 9-27-69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: 455 Bannock St Boi
23c. DATE SIGNED: 9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-29-69
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Oct. 2, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Robert G. Lee
LICENSE NO.: E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. Max Bell
315 W. Jefferson

Certificate of Death
STATE OF IDAHO

State File No. 4028
Local Reg. No. 635
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 50 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes 22	d. STREET ADDRESS (If rural, give location): 1004 North 8th

3. NAME OF DECEASED (Type or Print)	a. (First): Hilario	b. (Middle):	c. (Last): Arguinchona	4. DATE OF DEATH	(Month) 9	(Day) 28 (Year) 1969
5. SEX: Male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Feb. 13, 1900	9. AGE (In years last birthday): 69	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 28	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Amorebieta Vizcaye Spain	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: Domingo Arguinchona	BIRTHPLACE: Spain	14. MOTHER'S MAIDEN NAME: Maria Antonia Larrinaga	BIRTHPLACE: Spain			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-10-8454	17. INFORMANT'S OWN SIGNATURE: Henry B Arguinchona	ADDRESS: M.D.			

1621

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Caranoma of Lung. — INTERVAL BETWEEN ONSET AND DEATH: 9 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. *, 19*68*, to* 9/28 *, 19*69*, that I last saw the deceased alive on* 9/28/ *, 19*69*, and that death occurred at* 3:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Max L. Bell, M.D. 039 (Degree or title)	23b. ADDRESS: Boise, Idaho	23c. DATE SIGNED: 9/30/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10-1-1969	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho		
DATE REC'D BY LOCAL REG.: Oct. 7 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Erle B. Byram
LICENSE NO.: E-533		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

State File No. 4029
Local Reg. No. 619
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 01 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 03

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1714 North 18th Street

3. NAME OF DECEASED (Type or Print) a. (First) O. b. (Middle) ARLENE c. (Last) BLICKENSTAFF
4. DATE OF DEATH (Month) (Day) (Year) Sept. 28, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 26, 1918
9. AGE (In years last birthday) 51
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary
10b. KIND OF BUSINESS OR INDUSTRY Public Accountant
11. BIRTHPLACE (State or foreign country) Elston, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lou W. Allison
BIRTHPLACE Jewell Co., Kansas
14. MOTHER'S MAIDEN NAME Carey Gertrude Walters
BIRTHPLACE Hopeville, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. --
17. INFORMANT'S OWN SIGNATURE C. A. Blickenstaff
ADDRESS 1714 N. 18th Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1747

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic Ca Breast — INTERVAL BETWEEN ONSET AND DEATH 2 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15, 1969 to 9-28, 1969, that I last saw the deceased alive on 9-28, 1969, and that death occurred at 6:25 PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS 121 E. Idaho - Boise
23c. DATE SIGNED 9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-1-69
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery
24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 30, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Robert G. Rose
LICENSE NO. E-497
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

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SEP 30 1969
JAN 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JAN 30 1970
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4030
Local Reg. No. 631
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Gateway Trailer Park

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Alice	Dillon	9	28	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	divorced	4/18/1907	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Hiwasse, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Stringham — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Ivy Winona — BIRTHPLACE: ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ira Stahl — ADDRESS: Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Thyroid carcinoma — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumonia
DUE TO (c) 1937

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes, Hypertension

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1968, *to* Sept 28, 1969, *that I last saw the deceased alive on* 27 Sept, 1969, *and that death occurred at* 5:45a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert B. Montgomery M.D. 814	2121 College Blvd. Boise Id.	9/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
rem. bur.	10/1/69	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 2 1969	Myrtle Palmer	R. Dan Thomason	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4031
Local Reg. No. 640
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 001 OCT 10 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST LUKE'S HOSPITAL 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 823 EAST WASHINGTON

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BERT	RANDLE	HEATH	Sept. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	widowed	8-19-79	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grain Dealer 22		Oxford, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dinis Powis Albert Heath,	Glamorganshire, Wales	Mary Priannah Hillman	Salt Lake City, U.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
	519 07 3440	Conway Grant Family Records

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION 4122

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Vascular accident
DUE TO (c) Hypertensive Cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* September 19, 1969 *to* September 28, 1969 *that I last saw the deceased alive on* September 27 1969 *and that death occurred at* a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F.K. Root M.D. 447	6003 Overland Road	9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 2, 1969	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 9 1969	Myrtle Palmer	Conway Grant	E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4032
Local Reg. No. 628
Reg. Dist. No. 370

RECEIVED
Bureau of Vital Statistics
OCT 3 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Kansas
b. COUNTY 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Phillipsburg
d. STREET ADDRESS (If rural, give location) 845 N. 2nd St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Clyde	E.	Pfost	Sept. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 9, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer Retired		Glade, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David W. Pfost	Missouri	Fannie E. Hall	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
No	509-32-2008	Mrs Russell McKinley Glade, Kansas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hepatic Failure — 1569

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Biliary Carcinoma
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [XX] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September 15, 19 69, to September 29, 19 69, *that I last saw the deceased alive on* September 29, 19 69, *and that death occurred at* 7:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David Cawelti MD	Boise Idaho	9/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	10-1-69	Fairview Cemetery	Phillipsburg, Kansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 2, 1969	Myrtle Palmer	Les Snead	E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 8 1969
DEC 4 1969
AUG 10 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4033
Local Reg. No. 131
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH — OCT 9 1969
a. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: SUNSET NURSING HOME 230

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO b. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 3113 SYCAMORE DRIVE

3. NAME OF DECEASED (Type or Print): a. (First) OCE b. (Middle) OLA c. (Last) LOY ROBINSON
4. DATE OF DEATH (Month) (Day) (Year): SEPT. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	never married	AUG. 7, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Olney, Illinois	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Woodrow J. Smith	no record	Lydia Woodard	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519 12 3863	Russell C. Kelyea	

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CVA — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2/28, 1968, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
R Bruce Moody 368 (Degree or title) M.D.	2429 N. Cole Rd	10/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 2, 1969	Canyon Hill	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 9, 1969	Myrtle Palmer	Conway Grant	E478

FIRM NAME: Kelyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 9 1969

OCT 24 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4034
Local Reg. No. 633
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Ada

b. CITY OR TOWN: Boise

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 1106 N. 22nd St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Vincent	Joseph	McLin	Sept. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Sept. 5, 1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner- Idaho Automatic Welding		Waseca Co., Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew E. McLin	Minnesota	Mary Alice Cunningham	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	477-07-7087	Mrs. Alma McLin	Same

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary Atherosclerosis — unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-30-69	Extensive Atherosclerosis - all coronary Arteries	YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 9-6, 1969, *to* 9-30, 1969, *that I last saw the deceased alive on* 9-30, 1969, *and that death occurred at* 5:45 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Rodney H Hen M.D (Degree or title)	123 East Idaho St, Boise	10-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1969	Syringa Gardens	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 3, 1969	Myrtle Palmer	A. E. Alden	E-299

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alden-Waggoner Chapel

OCT 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4035
Local Reg. No. 129
Reg. Dist. No. 371

BIRTH NO.

RECEIVED OCT 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3½ Months
d. FULL NAME OF HOSPITAL OR INSTITUTION: Boise Valley Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada c/o
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Rural - P. O. Box 2271

3. NAME OF DECEASED (Type or Print): a. (First) HARVEY; b. (Middle) ALBERT; c. (Last) PUGH

4. DATE OF DEATH (Month) (Day) (Year): Sept. 30, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 5, 1874

9. AGE (In years last birthday): 95
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner-Manager of Lumber & Flour Mills

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Olney, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John William Pugh
BIRTHPLACE: Olney, Illinois

14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Fulk
BIRTHPLACE: Olney, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519-12-0979

17. INFORMANT'S SIGNATURE: Muriel L Pugh
ADDRESS: P. O. Box 2271 Boise, Idaho

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Heart attack. — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis — 2-3 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Cerebral art. sclerosis — 2-3 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1968, to Death, 19____, that I last saw the deceased alive on Sept 25, 1969, and that death occurred at 12:25 AM. From the causes and on the date stated above.

23a. SIGNATURE: O R Blackburn M D (Degree or title)

23b. ADDRESS: Boise, Ida

23c. DATE SIGNED: 2 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-2-69

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Oct. 9 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

26. EMBALMER: Lowell Lemaron

LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 13 1977

MAY 26 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4036
Local Reg. No. 17
Reg. Dist. No. 300

Certificate of Death

RECEIVED SEP 11 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Council Community Hospital 017

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitvale
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): Ermina
c. (Last): Hulse

4. DATE OF DEATH (Month) (Day) (Year): 9 7 1969

5. SEX: female
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 12/24/1884
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Fredrick Burt — BIRTHPLACE: ---
14. MOTHER'S MAIDEN NAME: Eunice Angell — BIRTHPLACE: ----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: x James R. Linn — ADDRESS: Council Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

174X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23, 1969, *to* 9-7, 1969, *that I last saw the deceased alive on* 9-7, 1969, *and that death occurred at* 8:15p. *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 154 (Degree or title)
23b. ADDRESS: Council, Idaho
23c. DATE SIGNED: 9/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/10/69
24c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery
24d. LOCATION (City, town, or county) (State): Council Admas Idaho

DATE REC'D BY LOCAL REG.: 9-10-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: R. Dale Thomason
LICENSE NO.: E 388

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

SEP 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4037
Local Reg. No. 308
Reg. Dist. No. 511

BIRTH NO.

RECEIVED
SEP 26 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN: Lava Hot Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valleyview Nursing Home 021

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1334 Yellowstone Avenue

3. NAME OF DECEASED (Type or Print): a. (First) ERNEST b. (Middle) D. c. (Last) GHAN

4. DATE OF DEATH: (Month) August (Day) 11 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 14, 1889

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Contracting

11. BIRTHPLACE (State or foreign country): Boaz Missouri

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Allen Ghan
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Becka Jane Pearce
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 518-18-1442

17. INFORMANT'S OWN SIGNATURE: Mrs. Lydia M. Ghan
ADDRESS: Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral vascular accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis
DUE TO (c) arteriosclerotic heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

4369

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1968, *to* Aug. 11, 1969, *that I last saw the deceased alive on* Aug. 11, 1969, *and that death occurred at* 1:40a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.

23b. ADDRESS: Downey, Idaho

23c. DATE SIGNED: Aug. 12, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 13, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 9-19-69

REGISTRAR'S SIGNATURE: Ida Mae Cunningham

25. EMBALMER: [signature]

LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4038
Local Reg. No. 294
Reg. Dist. No. 611

RECEIVED
Bureau of Vital Statistics
SEP 10 1969

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock (23)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital (218)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power (390)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Rockland
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): KEITH
b. (Middle): EARL
c. (Last): MOSS

4. DATE OF DEATH: (Month) Sept. (Day) 1, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 13, 1924

9. AGE (In years last birthday): 45
IF UNDER 1 YEAR: Months 2 Days 18
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (07)

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Lava Hot Springs, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: H. Irvin Moss
BIRTHPLACE: Chesterfield, Idaho

14. MOTHER'S MAIDEN NAME: Velma Byington
BIRTHPLACE: Lava Hot Springs, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 529-26-3809

17. INFORMANT'S OWN SIGNATURE: x Fae Moss
ADDRESS: Rockland, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1519

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Adenocarcinoma of stomach
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8/18/69

19b. MAJOR FINDINGS OF OPERATION: Nonresectable carcinoma stomach

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8/17/69, 19__, *to* 9/1/69, 19__, *that I last saw the deceased alive on* 9/1/69, 19__, *and that death occurred at* 3:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. W. McRobertson M.D.

23b. ADDRESS: 1448 East Center

23c. DATE SIGNED: 9/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem.&Burial

24b. DATE: 9-4-69

24c. NAME OF CEMETERY OR CREMATORY: Valley View Cemetery

24d. LOCATION (City, town, or county) (State): Rockland, Idaho

DATE REC'D BY LOCAL REG.: SEP 9 1969

REGISTRAR'S SIGNATURE: Florence Depew

25. EMBALMER: H. L. Davis

LICENSE NO.: E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 19 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 4039
Local Reg. No. 295
Reg. Dist. No. 511

BIRTH NO.

SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello	c. LENGTH OF STAY (In this place): b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019	d. STREET ADDRESS (If rural, give location): P. O. Box 73

3. NAME OF DECEASED (Type or Print) a. (First): NORINE	b. (Middle): LaRue Miner	c. (Last): CLAYSON	4. DATE OF DEATH (Month) (Day) (Year): Sept. 3, 1969	
5. SEX: Female	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: April 23,1924	9. AGE (In years last birthday): 45 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Kanosh, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: O. L. Miner	BIRTHPLACE: Fairview, Utah	14. MOTHER'S MAIDEN NAME: LaRue Mower	BIRTHPLACE: Fairview, Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: X Edward S. Clayson	ADDRESS: Box 73, Soda Springs	

18. CAUSE OF DEATH 5710
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute pyelonephritis with secondary renal shutdown

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Laenec's cirrhosis of the liver

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Id 4 or 5 days probably several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [XX] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 3, 1969, *to* Sept. 3, 1969, *that I last saw the deceased alive on* Sept. 3, 1969, *and that death occurred at* 4:45p *m., from the causes and on the date stated above.*

23a. SIGNATURE 101 J. E. Comstock (Degree or title): J E Comstock MD	23b. ADDRESS: Box 852 - Pocatello, Idaho	23c. DATE SIGNED: 9-15-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept.6,1969	24c. NAME OF CEMETERY OR CREMATORY: Provo	24d. LOCATION (City, town, or county) (State): Provo, Utah
DATE REC'D BY LOCAL REG.: SEP 17 1969	REGISTRAR'S SIGNATURE: Gloria Dopita	25. EMBALMER: Theron Miller	LICENSE NO.: E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED SEP 22 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4040
Local Reg. No. 296
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello; c. LENGTH OF STAY (In this place) 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location) 182 Hawthorne Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) GLENN	b. (Middle) C	c. (Last) HATFIELD	4. DATE OF DEATH (Month) Sept. (Day) 8 (Year) 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH June 27, 1893	9. AGE (In years last birthday) 76 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 22	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Moline, Illinois	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Squire R. Hatfield	BIRTHPLACE Kentucky	14. MOTHER'S MAIDEN NAME Freda M. Peterson	BIRTHPLACE Sweden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 552-05-3679	17. INFORMANT'S OWN SIGNATURE Glenna Wicker	ADDRESS Novato, Calif.	

18. CAUSE OF DEATH 4370
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive Cebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral-vascular arteriosclerosis — 3 yrs
DUE TO (c) Hypertension & age

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1964, *to* Sept. 8, 1969, *that I last saw the deceased alive on* Sept 8, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE John R. McMahon 347 (Degree or title) M.D.	23b. ADDRESS Pocatello Idaho	23c. DATE SIGNED 9/11/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sep 10, 1969	24c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cem.	24d. LOCATION (City, town, or county) Pocatello (State) Idaho
DATE REC'D BY LOCAL REG. SEP 15 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER George W. Knoff	LICENSE NO. E-409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

OCT 1 1969

BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 4041
Local Reg. No. 307
Reg. Dist. No. 511

Bureau of Vital Statistics

1. PLACE OF DEATH: Bannock 03

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Butte 120

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 4 hrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

d. STREET ADDRESS (If rural, give location): 230 Afton

3. NAME OF DECEASED (Type or Print): a. (First) HAZEL b. (Middle) c. (Last) FARMER

4. DATE OF DEATH (Month) (Day) (Year): Sept. 9, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 1, 1903

9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Arco, Idaho

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: B. Tim Combe — BIRTHPLACE: Italy

14. MOTHER'S MAIDEN NAME: Josephene Gardiol — BIRTHPLACE: Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Lorenzo S Farmer — ADDRESS: Arco, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3959

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Kidney Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aortic Stenosis — 20 yrs.
DUE TO (c) Chronic Glomerulonephritis — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart disease — 10 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1960, *to* Sept 9, 1969, *that I last saw the deceased alive on* Sept 9, 1969 *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 031 [signature] (Degree or title)

23b. ADDRESS: Arco, Ida

23c. DATE SIGNED: 9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-13-69

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Arco, Idaho

DATE REC'D BY LOCAL REG.: SEP 29 1969

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: E. H. Marvel

LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 1 1969

Bureau of Vital Statistics

State File No. 4042
Local Reg. No. 3059
Reg. Dist. No. 511

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannack 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 8 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony's Hospital 014

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Leo
b. (Middle): Ephriam
c. (Last): Moon

4. DATE OF DEATH: (Month) Sept. (Day) 10, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 14, 1916

9. AGE (In years last birthday): 52
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Malad, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Archie Moon
BIRTHPLACE: Malad, Idaho

14. MOTHER'S MAIDEN NAME: Esther Morse
BIRTHPLACE: Samaria, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-14-1388

17. INFORMANT'S OWN SIGNATURE: Nellie Moon
ADDRESS: Sterling, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 4109 Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Previous myocardial infarction — 5 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Pulmonary emphysema, severe — 10 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19 58, *to* Sept. 10, 19 69, *that I last saw the deceased alive on* Sept. 10, 1969, *and that death occurred at* 8:40 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. H. Anderson, M. D. 009 — (Degree or title): M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Sept. 18, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: SEP 30 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Dean Hill
LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4043
Local Reg. No. 303
Reg. Dist. No. 511

BIRTH NO.

RECEIVED OCT 1 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 390 McAdoo

3. NAME OF DECEASED (Type or Print) a. (First) Sarah b. (Middle) Celestial c. (Last) Brady Cook

4. DATE OF DEATH (Month) (Day) (Year) Sept. 11, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 24, 1901

9. AGE (In years last birthday) 68
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Fairview, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jarion Brady BIRTHPLACE Mt. Pleasant, Utah

14. MOTHER'S MAIDEN NAME Huntington, Utah BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 528-30-9268

17. INFORMANT'S OWN SIGNATURE J. Calvert Cook ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4379

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Addident

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute occlusion right common iliac artery, secondary to arteriosclerosis.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 9/9/69

19b. MAJOR FINDINGS OF OPERATION Ischemic right leg. Above Knee amputation done

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* Sept. 11, 1969, *that I last saw the deceased alive on* Sept. 11, 1969, *and that death occurred at* 11:55p m., *from the causes and on the date stated above.*

23a. SIGNATURE C. W. McC. Roberts (Degree or title) M.D.

23b. ADDRESS Pocatello, Idaho

23c. DATE SIGNED Sept. 18, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 15, 1969

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) Blackfoot, Idaho (State)

DATE REC'D BY LOCAL REG. SEP 30 1969

REGISTRAR'S SIGNATURE Gloria Dopita

25. EMBALMER C. Dean Hill

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4044
Local Reg. No. 298
Reg. Dist. No. 570

BIRTH NO.

RECEIVED SEP 26 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 037
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 037
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 419 So. Garfield

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOSEPH	I.	LINDSAY	Sept. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 16, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bldg. Contractor	Construction	Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Lindsay	Utah	Mary Ann Beck	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-12-2483A	Mrs. Eva Lindsay	Pocatello, Idaho

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Sudden death	Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic H.T. dis	mos 69
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Prostatic Obstruction	Aug 69

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Pocatello Bannock Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Mar 22, 1969, to Sept 14, 1969, that I last saw the deceased alive on Sept 10, 1969 and that death occurred at 6:30a.m., from the causes and on the date stated above.

23a. SIGNATURE (Physician or Coroner)	23b. ADDRESS	23c. DATE SIGNED
[signature] 248	Pocatello Idaho	9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-18-1969	Dingle Cem.	Dingle, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 23 1969	Gloria Hopite	John P. Downard	E-292

FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 3 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4045
Local Reg. No. 304
Reg. Dist. No. 510

Certificate of Death

RECEIVED
OCT 1 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 219

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 215 Taft Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): LeROY
c. (Last): CUDABACK

4. DATE OF DEATH (Month) (Day) (Year): September 19 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: December 29, 1896
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist 10
10b. KIND OF BUSINESS OR INDUSTRY: Union Pacific R. R.
11. BIRTHPLACE (State or foreign country): Callaway Nebraska
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME BIRTHPLACE: James Porter Cudaback
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Elizabeth Van Tassel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: 505-26-7110
17. INFORMANT'S OWN SIGNATURE: Elvin L. Cudaback — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease & cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Severe Rheumatoid arthritis — yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1956, 19__, *to* Sept. 19, 1969, *that I last saw the deceased alive on* Sept. 19, 19 69 *and that death occurred at* 10:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 362 David C. Miller, M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Sept. 22, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 23, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: SEP 26 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 1 1969

OCT 22 1982

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4046
Local Reg. No. 305
Reg. Dist. No. 510

RECEIVED
OCT 1 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 5155 Yellowstone

3. NAME OF DECEASED (Type or Print)
a. (First): VERA
b. (Middle): BERNICE
c. (Last): McGREW

4. DATE OF DEATH (Month) (Day) (Year): Sept. 19, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Feb. 6, 1915

9. AGE (In years last birthday): 54
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Bloomington, Neb.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Whelan
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Edna Favinger
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Elin M. McGrew
ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4121

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arterio sclerotic heart Disease — 1 year
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Hypertensive Cardio-Vascular Renal

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April, 1969, *to* Sept 19, 1969, *that I last saw the deceased alive on* Sept 19, 1969, *and that death occurred at* 7:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Kendrick Bldg

23c. DATE SIGNED: 9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sep. 22, 1969

24c. NAME OF CEMETERY OR CREMATORY: Casper Cemetery

24d. LOCATION (City, town, or county) (State): Casper, Wyoming

DATE REC'D BY LOCAL REG.: SEP 30 1969

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Theron Miller

LICENSE NO.: E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4047
Local Reg. No. 299
Reg. Dist. No. 510

BIRTH NO.

RECEIVED SEP 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 250 South 13th Avenue 000	d. STREET ADDRESS (If rural, give location) 250 South 13th Avenue

3. NAME OF DECEASED (Type or Print) a. (First) EVA	b. (Middle)	c. (Last) PETERSEN	4. DATE OF DEATH (Month) (Day) (Year) Sept. 19, 1969	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Feb.17, 1888	9. AGE (In years last birthday) 81 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Uppsala, Sweden	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Holmgren	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) XXXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Lyle L. Petersen	ADDRESS Pocatello	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic heart

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Disease & acute condition arrest.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 9-19-, 19 69, *that I last saw the deceased alive on* 9-19-69, 19__, *and that death occurred at* 8P *m., from the causes and on the date stated above.*

23a. SIGNATURE 36 David C. Miller, M.A.C. (Degree or title)	23b. ADDRESS Pocatello, Idaho	23c. DATE SIGNED 9-23-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sep.23,1969	24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery	24d. LOCATION (City, town, or county) (State) Paul, Idaho
DATE REC'D BY LOCAL REG. SEP 24 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Theron Miller	LICENSE NO. E-534

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 26 1969

JUN 8 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4048
Local Reg. No. 3888
Reg. Dist. No. 510

RECEIVED OCT 1 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 021
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 021
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MABEL	PAULINE	HAVLICAK	Sept. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Divorced	July 12, 1885	84	2	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Dennison, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William T. Gabbert	Texas	Laura E. LaMar	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-58-9064	X Paula Hayes	Rockland, Idaho

MEDICAL CERTIFICATION

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: app 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — several years
DUE TO (c) Generalized arteriosclerosis — several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 1, 1969, *to* Sept 20, 1969, *that I last saw the deceased alive on* Sept 20, 1969, *and that death occurred at* 11:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J E Comstock MD	Box 852 - Pocatello Idaho	9-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	9-24-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 29 1969	Gloria Dopita	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4049
Local Reg. No. 310
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 OCT 10 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 3633 Jason

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First) FLOYD b. (Middle) P. c. (Last) WALKER

4. DATE OF DEATH (Month) (Day) (Year) Sept. 22, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Aug. 20, 1920

9. AGE (In years last birthday) 49
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter 10

10b. KIND OF BUSINESS OR INDUSTRY U.P.R.R.

11. BIRTHPLACE (State or foreign country) Marysville, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George W. Walker
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Zola Prindle
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II 4

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE ADDRESS
x Mrs. Floyd P. Walker

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Coronary

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Heart disease, with Recent myocardial infarction, and
DUE TO (c) old healed myocardial

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. infarction of Rt. Ventricle

INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1967, 19__, to 9-22-, 1969, that I last saw the deceased alive on 9-22, 1969, and that death occurred at 7:45 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) David C. Miller, MD

23b. ADDRESS Pocatello Idaho

23c. DATE SIGNED 10-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 26, 1969

24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery

24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. OCT 7 1969

REGISTRAR'S SIGNATURE Gloria Doerte

25. EMBALMER Theron Spiller

LICENSE NO. E-532

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 10 1969
OCT 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated; and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4050
Local Reg. No. 387
Reg. Dist. No. 510

BIRTH NO.

OCT 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hiline Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1357 Santa Anita Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): KEITH
b. (Middle): LEON
c. (Last): WARNER

4. DATE OF DEATH (Month) (Day) (Year): September 23 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: September 2, 1922
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter 21
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): Parker Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Wayne T. Warner — BIRTHPLACE: Anaconda, Montana
14. MOTHER'S MAIDEN NAME: Zoie Southworth — BIRTHPLACE: Wilford, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II 4
16. SOCIAL SECURITY NO.: 518-20-1992
17. INFORMANT'S OWN SIGNATURE: Mrs Keith Warner — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gunshot wound in Left Eye and Brain — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 2 Suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): County road 31
21c. (CITY, TOWN, OR TOWNSHIP) 030 (COUNTY) (STATE): Pocatello Bannock Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 23 1969 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify* ~~that I attended the deceased from xxxxxxxxxxxx, 19xxx, to xxxxxxxxxxxx, 19xxx~~, *that I* ~~last~~ *saw the deceased* dead ~~alive~~ *on* Sept. 23, 1969, *and that death occurred at* not known *from the causes and on the date stated above.*

23a. SIGNATURE: Burton H. John 583 4 (Degree or title): Bannock County Coroner
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Sept. 25, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: SEP 26 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

OCT 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 18 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4051
Local Reg. No. 317
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 303 North Hayes

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRED	W.	BROWN	Sept. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Widowed	July 10, 1880	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
10 Union Pacific Railroad		Sandy, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
A.H. Brown	England	Francis Terman	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No / XXXX		Deane W. Brown	Price, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

2001

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Retroperitoneal lymphasarcoma — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August 31, 1969 *to* September 24, 1969, *that I last saw the deceased alive on* September 24, 1969, *and that death occurred at* 7:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. H. Anderson, M. D. 009	1448 E. Center Pocatello, Ida.	Oct. 6, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 27, 1969	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 14 1969	Gloria Dopita	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969

MAR 30 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4052
Local Reg. No. 388
Reg. Dist. No. 510

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 OCT 7 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Convalscent Home 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1071 Renee Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JACK	SYLVESTER	ROUBIDOUX	September 28 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	March 4, 1930	39				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Invalid 28
10b. KIND OF BUSINESS OR INDUSTRY *****
11. BIRTHPLACE (State or foreign country) Lava Hot Springs Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Syvlester M. Roubidoux
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Zella Godfrey
BIRTHPLACE Newton, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) *****
16. SOCIAL SECURITY NO. 518-38-6095
17. INFORMANT'S OWN SIGNATURE Zella Blaser
ADDRESS Lava Hot Springs Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema
DUE TO (c) Asthma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe Neuro Muscular Disease Type Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1960, 19___, *to* Sept. 28, 1969, *that I last saw the deceased alive on* Sept. 24, 1969, *and that death occurred at* 9:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Pocatello Idaho	Sept. 30, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 1, 1969	Lund Cemetery	Lund Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 2 1969	Gloria Dopita	[signature]	E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 4053
Local Reg. No. 309
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 OCT 7 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) 3 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Rest Home 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 225 W. Bridger

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HENRY	A	BROWN	Sept.	29	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Nov. 4, 1882	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer 10	Railroad	Dade County, Mo.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Brown	Iowa	Margaret Day	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	712-01-7105A	Hazel Zweigart	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severe Chronic Emphysema & Pulmonary Fibrosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Cystitis, prostatic Hypertrophy

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1961, 19__, to 29 Sept, 1969, that I last saw the deceased alive on 14 Sept, 1969, and that death occurred at 7:42 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clark Parkinson MD	P.O. Box 1746 Pocatello Ida	30 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 2, 1969	Mountainview	Pocatello Idaho

DATE REC'D BY REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 2 1969	Gloria Donita	George W. Knapp	E-409

FIRM NAME: Howard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4054
Local Reg. No. 375
Reg. Dist. No. 510

BIRTH NO.

RECEIVED

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bannock 05 — OCT 15 1969

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello — Bureau of Vital Statistics

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 918

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: Bannock 03

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello

d. STREET ADDRESS (If rural, give location): Hillcrest Haven Convalscent Home

3. NAME OF DECEASED (Type or Print): a. (First) MAUDE — b. (Middle) — c. (Last) HANNIFAN

4. DATE OF DEATH (Month) (Day) (Year): September 29, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: October 12, 1891

9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pocatello Idaho

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Parley J. Burton — BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Sara Ann Cowley — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 519-09-9931 D

17. INFORMANT'S OWN SIGNATURE: L G Burton — ADDRESS: Provo, Utah

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident (Stroke) — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cerebral Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, *19*____, *to* Sept. 29, *19* 69, *that I last saw the deceased alive on* Sept. 29, *19* 69 *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Calvin Buhler MD

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: Oct. 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 2, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: OCT 1 3 1969

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Jack Henderson — LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4055
Local Reg. No. 318
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: BANNOCK 03 | b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello | c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho | b. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 595 Euclid Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDWARD		HILL	Sept. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	married	Dec. 29, 1908	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
10	P.F.E.	Malad, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward N. Hill	St. John, Idaho	Annie E. Evans	Malad, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Earlie Hill	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Generalized severe pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cor pulmonale — 2 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April 23, 1968, to September 29, 1969, that I last saw the deceased alive on September 29, 1969, and that death occurred at 3:20a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. H. Anderson, M. D.	1448 E. Center Pocatello, Ida.	Oct. 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 2, 1969	St. John Cemetery	Malad, Oneida, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 14 1969	Gloria Dopita	Theron Miller	E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4056
Local Reg. No. 321
Reg. Dist. No. 518

BIRTH NO.

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 012

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 235 South 17th. Avenue

3. NAME OF DECEASED (Type or Print): a. (First) FLORA; b. (Middle) P.; c. (Last) WRIGHT

4. DATE OF DEATH (Month) (Day) (Year): September 30, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: February 3, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Thatcher Idaho

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Lewis S. Pond
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Julia Whittle
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 519-56-6540

17. INFORMANT'S OWN SIGNATURE: LaRue Treasure
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarct
INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello Bannock Ida
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* [illegible], *19*___, *to* Sept. 30, *1969*, *that I last saw the deceased alive on* Sept. 30, *1969*, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 248
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Oct. 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Thatcher Cemetery
24d. LOCATION (City, town, or county) (State): Thatcher Idaho

DATE REC'D BY LOCAL REG.: OCT 14 1969
REGISTRAR'S SIGNATURE: Gloria Doyle
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 7 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics
SEP 18 1969

Certificate of Death

STATE OF IDAHO

State File No. 4057
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Alton Idaho
c. LENGTH OF STAY (in this place) 4 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 007

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston Idaho
d. STREET ADDRESS (If rural, give location) Route II

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Warren		Edwards	Sept 1 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Jan 21 1895	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer		Mink Creek Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin Edwards	unknown	Hannah Jodson	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes World War I	518-07-9794	Fern Edwards	469 Wakefield Twin Falls Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) From his family history
DUE TO (c) He has had trouble with

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death his heart for the last 4 or 5 years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vile Matthews 583 Coroner	Montpelier Idaho	Sept 2 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Sept 2 1969	Riverdale Cemetery	Riverdale Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/2/69	Ruby Gotcnsky	Vile Matthews	E359

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4058
Local Reg. No.
Reg. Dist. No. 552

RECEIVED
SEP 18 1969
Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL) Near Border (Bear Lake township)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) On highway 30 Near

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier 040
d. STREET ADDRESS (If rural, give location) 327 So 7th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Kevan	Wade	Kuetch	Sept. 6 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Oct 1 1952	16				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student in High School		Montpelier Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Darrell Kuetch	Dingle Idaho	Rhoda Jean Sparks	Dingle Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Darrell Kuetch	Montpelier Idaho

8159

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Automobile Accident — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Just West of Border Hwy Highway 30 N
DUE TO (c) About 2 Miles Car hit rail

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Guard and Jumped over R.R.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Went down an embankment.	YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 30 N. Near Border	040 Bear Lake Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Mike Matthews 583 Coroner	Montpelier Idaho	Sept 8 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 9 1969	Wardboro Cemetery	Wardboro Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 9 1969	Ruby Gorczinsky	Mike Matthews	E 359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 4059
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN Bennington
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bennington
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Willis	Evan	Skinner	Sept. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Sept. 28, 1960	8 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
DD		Soda Springs, Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isaac LaVell Skinner	Conda, Idaho	Connie Roberts	Lanark, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			Isaac L. Skinner	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Atrophy. Etiol Undetermined 3471 — INTERVAL BETWEEN ONSET AND DEATH: UNKOWN

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe cachexia & mental retardation. — Several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-10, 1969, *to* 9-11, 1969, *that I last saw the deceased alive on* 9/11, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Montpelier Idaho	9/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Sept. 15 1969	Fairview Cemetery	Soda Springs Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/17/69	Ruby Gatewisky	Mike Matthews	E 359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 7 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4060
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
c. LENGTH OF STAY (in this place) 1 Mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Hospital 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bayette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Ransom b. (Middle) Carey c. (Last) Van Leuven

4. DATE OF DEATH (Month) Sept. (Day) 20 (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Mar. 28, 1893

9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 07

10b. KIND OF BUSINESS OR INDUSTRY Dairy farm

11. BIRTHPLACE (State or foreign country) Lewiston, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Ransom Carlos Van Leuven — BIRTHPLACE N. Ogden, Ut.

14. MOTHER'S MAIDEN NAME Sarah Lucinda Lake — BIRTHPLACE Harrisville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 09 2117

17. INFORMANT'S OWN SIGNATURE Sarah VanLeuven — ADDRESS Nero Plymouth Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4379

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Uremia & Renal Failure — INTERVAL BETWEEN ONSET AND DEATH 72 Hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Vascular Accident — 3 weeks
DUE TO (c) Cerebral Vascular Insuffic — 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 27, 1969, *to* Sept 20, 1969, *that I last saw the deceased alive on* Sept 20, 1969, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Montpelier Idaho

23c. DATE SIGNED 9/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Sept. 23, 1969

24c. NAME OF CEMETERY OR CREMATORY Dayton

24d. LOCATION (City, town, or county) Dayton (State) Idaho

DATE REC'D BY LOCAL REG. 9/22/69

REGISTRAR'S SIGNATURE Ruby Gontinsky

25. EMBALMER Sherwin Webb — LICENSE NO. 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

APR 14 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4061
Local Reg. No. 42
Reg. Dist. No. 130

RECEIVED Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Benewah (050)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Community Hosp. (025)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington (48)
b. COUNTY: Spokane (555)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): 3914 West Crown

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): EARL
c. (Last): JANSSEN

4. DATE OF DEATH (Month) (Day) (Year): Sept. 6 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 20, 1947
9. AGE (In years last birthday): 22 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Disability Retirement
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army
11. BIRTHPLACE (State or foreign country): North Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harvey Earl Janssen (28) — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Beverly J. Mooke — BIRTHPLACE: S.D.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Jan. 1964 - Feb 7 1965
16. SOCIAL SECURITY NO.: 556-72-8351
17. INFORMANT'S OWN SIGNATURE: Arden Janssen — ADDRESS: 3914 W. Crown Spokane

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremic coma — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Pyelonephritis and — 1 wk
DUE TO (c): Septicemia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-1, 1969, *to* 9-6, 1969, *that I last saw the deceased alive on* 9-6, 1969, *and that death occurred at* 2:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: B. A. Rapp (428) — (Degree or title): M.D.
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 8 1969
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24d. LOCATION (City, town, or county) (State): St. Maries, Idaho

DATE REC'D BY LOCAL REG.: Sept. 8, 1969
REGISTRAR'S SIGNATURE: Donna Brown
25. EMBALMER: Gerald Browning — LICENSE NO.: E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 15 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 21 1989

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-7824
BIRTH NO.

Certificate of Death

RECEIVED
SEP 22 1969
Bureau of Vital Statistics
STATE OF IDAHO

State File No. 4062
Local Reg. No. 43
Reg. Dist. No. 130

1. PLACE OF DEATH
a. COUNTY: Benewah 009
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
STAY (in this place): 24 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Comm. Hosp. 035

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Benewah 009
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fernwood
d. STREET ADDRESS (If rural, give location): Box 10

3. NAME OF DECEASED (Type or Print)
a. (First): TINA
b. (Middle): Joy
c. (Last): SILER

4. DATE OF DEATH (Month) (Day) (Year): Sept. 6 1969

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Aug. 13, 1969

9. AGE (In years last birthday): IF UNDER 1 YEAR — Months: ; Days: 24 ; IF UNDER 24 HRS. — Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Randy Siler
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Chysta I. Relan
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Randy E. Siler
ADDRESS: Fernwood, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Prematurity (2 lbs 10 oz)
INTERVAL BETWEEN ONSET AND DEATH: 24 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12 Aug, 1969, *to* 6 Sept, 1969, *that I last saw the deceased alive on* 5 Sept, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): Ed Sullivan MD
23b. ADDRESS: St Maries Idaho
23c. DATE SIGNED: 9/14/1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 10, 1969
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: Sept. 18, 1969
REGISTRAR'S SIGNATURE: Donna Brown

25. EMBALMER: Gerald Browning E-411
LICENSE NO.:
FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4063
Local Reg. No. 45
Reg. Dist. No. 130

RECEIVED OCT 9 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah 050
b. CITY OR TOWN St. Maries
c. LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2 mi N. of St. Maries Hwgh 95A

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) Route #1, Box #115

3. NAME OF DECEASED (Type or Print) a. (First) DOUGLAS b. (Middle) EUGENE c. (Last) McGLOCKLIN

4. DATE OF DEATH (Month) (Day) (Year) September 13, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Dec. 3, 1954
9. AGE (In years last birthday) 14 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Bonners Ferry, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Eugene McGlocklin BIRTHPLACE Bonners Ferry, Idaho
14. MOTHER'S MAIDEN NAME Betty Monk BIRTHPLACE Karney, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — —
16. SOCIAL SECURITY NO. 519-62-4192
17. INFORMANT'S OWN SIGNATURE Gene W. McGlocklin ADDRESS Bonners Ferry, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Compound Skull fractures — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 2 mi no. St. Maries
21c. (CITY, TOWN, OR TOWNSHIP) St. Maries (050 COUNTY) Benewah (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from D O A, 19___, to ___, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at 2:22 P m., from the causes and on the date stated above.

23a. SIGNATURE B. A. Rapp 725 (Degree or title) M.D.
23b. ADDRESS St. Maries, Idaho
23c. DATE SIGNED 9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/17/69
24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 7, 1969
REGISTRAR'S SIGNATURE Donna Brown
25. EMBALMER Gerald E. Browning
LICENSE NO. E-411
FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 29 1969

APR 24 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to report the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4064
Local Reg. No. 44
Reg. Dist. No. 130

STATE OF IDAHO

BIRTH NO.

RECEIVED
OCT 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: BENEWAH 052
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): St. Maries
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BENEWAH COMM. HOSPITAL 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: BENEWAH 052
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): PLUMMER, IDAHO
d. STREET ADDRESS (If rural, give location): BOX 184

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	HOOD	UNION	WORTHINGTON	SEPT.	16,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED	JUNE 27, 1903	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
POLE YARD OPERATOR 22	CEDAR POLE BUSINESS	ROSALIA, WASHINGTON	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JAMES T. WORTHINGTON	KENTUCKY	LAURA WELLS	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		519-26-8230-A	Valley Worthington	

MEDICAL CERTIFICATION

4360

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral vascular Accident Left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 25 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Hypertension — ? 20 yrs.

DUE TO (c): Diabetes Mellitus — ? 5 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug, 1969, *to* 16 Sept, 1969, *that I last saw the deceased alive on* 16 Sept, 1969, *and that death occurred at* 9:42 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ena Sullivan MD	St. Maries Idaho	20 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	SEPT. 20, 1969	PLUMMER CEMETERY	PLUMMER, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Oct. 1, 1969	Donna Brown	JAEGER FUNERAL HOME	ROSALIA, WASH.

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

OCT 8 1969

AUG 2 3 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4065
Local Reg. No. 120
Reg. Dist. No. 600

BIRTH NO. 69-7862

RECEIVED SEP 29 1969

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) 10 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) BARTHOLOMEW b. (Middle) c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year) August 29, 1969

5. SEX male

6. COLOR OR RACE Am. Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH August 29,1969

9. AGE (In years last birthday) IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 02

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Blackfoot,Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David Smith BIRTHPLACE Hays,Montana

14. MOTHER'S MAIDEN NAME Wilma Wesaw BIRTHPLACE Ft. Hall,Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Wilma W Smith ADDRESS Blackfoot,Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Prematurity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 29, 1969, *to* August 29, 1969, *that I last saw the deceased alive on* August 29, 1969, *and that death occurred at* 10a. *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 404 (Degree or title) M.D.

23b. ADDRESS Blackfoot,Idaho

23c. DATE SIGNED Sept 1,1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Sept 1,1969

24c. NAME OF CEMETERY OR CREMATORY Gibson Cemetery

24d. LOCATION (City, town, or county) (State) Ft. Hall reservation,Idaho

DATE REC'D BY LOCAL REG. SEP 26 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER C. Dean Hill

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 1 5 1969

Bureau of Vital Statistics

State File No. 4066
Local Reg. No. 118
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 007
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 3 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pingree
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Raymond	E.	Gardner	September 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	August 8, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Mapleton, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Gardner	Utah	Effie Clements	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	519-10-1843		Pingree, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept. 1, 1969, to September 2, 1969, that I last saw the deceased alive on September 2, 1969, and that death occurred at 12:15a m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	404 M.D.	Blackfoot, Idaho	Sept. 5, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 5, 69	Ammon Cemetery	Ammon, Bonneville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 11, 1969	Dorothy J. Jones	[signature]	E-466

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

JAN 27 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4067
Local Reg. No. 119
Reg. Dist. No. 601

BIRTH NO.

RECEIVED SEP 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 005
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moreland Rural
c. LENGTH OF STAY (In this place) Life
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moreland Rural
d. STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print) a. (First) Ricky b. (Middle) Carlyle c. (Last) Keller
4. DATE OF DEATH (Month) (Day) (Year) September 6, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH July 31, 1957
9. AGE (In years last birthday) 12
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 03
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Carl Keller BIRTHPLACE Milo, Idaho
14. MOTHER'S MAIDEN NAME Jane Cook BIRTHPLACE Blackfoot, Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Jane Keller ADDRESS Moreland, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9229

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) shot in heart — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with 410 gauge shot gun
DUE TO (c) by 6 year old brother accidently

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 31
21c. (CITY, TOWN, OR TOWNSHIP) Moreland (COUNTY) 060 Bingham (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from XX, 19XX, XXXX

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 4068
Local Reg. No. 121
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Bingham 061 SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Bingham Memorial Hospital 029

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 60 Cedar

3. NAME OF DECEASED (Type or Print) a. (First) Lillian b. (Middle) Butler c. (Last) Clark
4. DATE OF DEATH (Month) (Day) (Year) Sept. 13, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 24, 1928
9. AGE (In years last birthday) 41
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Basalt, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Sam Butler BIRTHPLACE Rexburg, Idaho
14. MOTHER'S MAIDEN NAME Emily Adams BIRTHPLACE Grace, Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-26-0948
17. INFORMANT'S OWN SIGNATURE Donald R Clark ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 174X Metastatic Carcinoma
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) of Breast
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 19 mos.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 68, to Sept 13, 19 69, that I last saw the deceased alive on Sept. 13, 19 69, and that death occurred at 9:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE Ralph Sloate 183 (Degree or title) M.D.
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED Sept. 16, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 16, 69
24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery
24d. LOCATION (City, town, or county) (State) Blackfoot, Idaho

DATE REC'D BY LOCAL REG. Sept. 19, 1969
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER C. Dean Hill LICENSE NO. E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4069
Local Reg. No. 122
Reg. Dist. No.

RECEIVED SEP 29 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 6 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 309 south Cleveland St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	LELAND	JENSEN	September 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	December 28, 1902	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintenance 08	State Hospital	Hyrum, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hans B. Jensen	Hyrum, Utah	Helena Christiansen	Hyrum, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-18-6583	Blanche Jensen	Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Coronary Arteriosclerosis — 30 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ——— , 19 60 , *to* Sept 21, , 19 69 , *that I last saw the deceased alive on* Sept 21 , 19 69 , *and that death occurred at* ——— *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean Packer M.D.	Blackfoot, Idaho	Sept 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept 24, 1969	Hillcrest cemetery	Shelley Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 26 1969	Dorothy J. Jones	E. Dean Hill	E-280

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 1969

JAN 29 1975

JUL 9 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 6 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4070
Local Reg. No. 123
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH — a. Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot - Rural
d. STREET ADDRESS (If rural, give location) N. of City, Rt. #1

3. NAME OF DECEASED (Type or Print) — a. (First) Aloha — b. (Middle) M. — c. (Last) Kerr

4. DATE OF DEATH (Month) (Day) (Year) Sept. 23, 1969

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH May 9, 1916
9. AGE (In years last birthday) 53 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Oakley, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Raymond Elliott McMurray — BIRTHPLACE Oakley, Idaho
14. MOTHER'S MAIDEN NAME Lillian Wilson — BIRTHPLACE Oakley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-07-2520
17. INFORMANT'S OWN SIGNATURE Robert M Kerr Jr — ADDRESS Box 708 Blackfoot, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Leukemia, Chronic Myelogenous — INTERVAL BETWEEN ONSET AND DEATH 2 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 48, *to* Sept 23, 19 69, *that I last saw the deceased alive on* Sept 23, 1969, *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Emerill Packham M.D.
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED 9-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-26-69
24c. NAME OF CEMETERY OR CREMATORY Fielding Memorial Cem.
24d. LOCATION (City, town, or county) (State) Idaho Falls, Bonneville, Idaho

DATE REC'D BY LOCAL REGISTRAR SEP 30 1969
REGISTRAR'S SIGNATURE Dorothy J Jones
25. EMBALMER Howard Packham
LICENSE NO. #E-338

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Howard Packham Mortuary

DUTIES:

OCT 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED OCT 13 1969

Bureau of Vital Statistics

State File No. 4071
Local Reg. No. 125
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 4 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): Route 4

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NATHAN	ORLEY	YANCEY	September 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	July 23, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Farmer	Agriculture	Chesterfield, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Adam Yancey		Alice Tolman	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	579-20-9473	Elda R Yancey	Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

185X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Prostate Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan, 1955, *to* September 24, 19 69, *that I last saw the deceased alive on* September 24, 19 69, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean Sacher M.D.	Blackfoot, Idaho	Sept 25, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept 27, 1969	Groveland Cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 9 1969	Dorothy J. Jones	Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 14 19

JUL 24 2014

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4072
Local Reg. No. 126
Reg. Dist. No. 600

RECEIVED OCT 13 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 1yr22da
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Carey
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES	R.	CAREY	Sept. 26 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	22 May 1886	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jim Carey — BIRTHPLACE Wisconsin
14. MOTHER'S MAIDEN NAME Sarah Henderson — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 518 30 2198
17. INFORMANT'S OWN SIGNATURE Mary Layne ADDRESS Med. Records-State Hospital South

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 486X Severe Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 Aug., 19 68 *to* 26 Sept., 19 69, *that I last saw the deceased alive on* 26 Sept, 19 69, *and that death occurred at* 11:30a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Leon F. Marlowe 594 (Degree or title) M.D.
23b. ADDRESS State Hospital South, Blackfoot, Idaho
23c. DATE SIGNED 9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 1, 1969
24c. NAME OF CEMETERY OR CREMATORY Carey Cemetery
24d. LOCATION (City, town, or county) Carey (State) Idaho

DATE REC'D BY LOCAL REG. OCT 9 1969
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER L. Dean Hill
LICENSE NO. E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home For Bird Mortuary - Hailey Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4073
Local Reg. No. 1241
Reg. Dist. No. 601

BIRTH NO.

RECEIVED
OCT 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley, R#1
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) R#1 Shelley,
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Theda	L	Cox	Sept.	27	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Nov 3 1919	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Hooper Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin Manning	Hooper	Vergie Garner	Hooper Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	528-18-2561	Jay E Cox	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severe Brain Damage — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Broken neck & multiple injuries
DUE TO (c) Car accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	06	060

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
9	27	69	P m.		

22. I hereby certify that I attended the deceased from Did not see victim alive to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl Storey 583	Coroner	321 E Walker Blackfoot	9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 1, 1969	Taylor Cemetery	Idaho Falls, R#3 Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-30-1969	Dorothy J. Jones	Floyd M Walden	E-275

FIRM NAME Walden's Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

State File No. 4074
Local Reg. No. 127
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN Blackfoot
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 029 Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN Rural Firth
d. STREET ADDRESS (If rural, give location) Rt. #1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	LORNA	JULIA	HIGLEY	Sept.	28,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married	July 31, 1928	41	1	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wife and Mother	Own Home	Grantsville, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leonard Earl Hale	Utah	Millie Julia Cassity	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			X William J. Higley	Rt.#1, Firth, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pyelonephritis 340X — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple sclerosis, chronic severe, advanced — 2 years +
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. decubiti, emaciation

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 18 May, 1969 *to* 28 Sept, 1969, *that I last saw the deceased alive on* 28 Sept, 1969 *and that death occurred at* 8:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 361	M.D.	Blackfoot, Idaho 9 Airport Road	9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-1-69	Grove City Cemetery	Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 10 1969	Dorothy J. Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 27 1973

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 18 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 13 1969

Bureau of Vital Statistics

State File No. 4075
Local Reg. No. 128
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bingham 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham County Nursing Home 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): North Fairgrounds

3. NAME OF DECEASED (Type or Print): a. (First) ROY b. (Middle) LARD c. (Last)

4. DATE OF DEATH: (Month) (Day) (Year) September 28, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: September 16, 1882

9. AGE (In years last birthday): 87
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Livestock

11. BIRTHPLACE (State or foreign country): El Paso, Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE
ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema. — 10 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19 50, to September 28, 19 69, that I last saw the deceased alive on Sept 28, 19 69, and that death occurred at 6:00p.m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] 404 (Degree or title) M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Oct 3, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Oct 2, 1969

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county): Blackfoot (State): Idaho

DATE REC'D BY LOCAL REG.: OCT 9 1969

REGISTRAR'S SIGNATURE: Dorothy J Jones

25. EMBALMER: L Dean Hill

LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 1 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4076
Local Reg. No. 24
Reg. Dist. No. 410

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (If not in place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural, Ketchum
d. STREET ADDRESS (If rural, give location): Warm Springs Road

3. NAME OF DECEASED (Type or Print)
a. (First): CARL EDWARD
b. (Middle): BRANDT
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Sept. 2, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: March 8. 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self 26
10b. KIND OF BUSINESS OR INDUSTRY: swinning pool
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: A.W. Brandt — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Cecila UNK — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 545-32-7544-8
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Ketchum, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): C.V.A.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Uremia
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1959, *to* 9-2, 1969, *that I last saw the deceased alive on* 9-2, 1969, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 374 (Degree or title) MD
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 9/5/69
24c. NAME OF CEMETERY OR CREMATORY: Mt. View crematory
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Sept 11-1969
REGISTRAR'S SIGNATURE: Robert H. Wright for C.B.W.
25. EMBALMER: Keith Bird [signature]
LICENSE NO.: E-373
FIRM NAME: Bird Funeral Home Hailey, Idaho.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4077
Local Reg. No. 33
Reg. Dist. No. 410

Certificate of Death

BIRTH NO.

RECEIVED OCT 15 1969 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): 416 2nd Street

3. NAME OF DECEASED (Type or Print)
a. (First): Waino
b. (Middle): Arthur
c. (Last): Kaattari

4. DATE OF DEATH (Month) (Day) (Year): Sept. 19, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 21, 1901
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Metall Urgist 07
10b. KIND OF BUSINESS OR INDUSTRY: Minning
11. BIRTHPLACE (State or foreign country): Fitzberg Massachusetts
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: UNK. BIRTHPLACE: UNK
14. MOTHER'S MAIDEN NAME: UNK BIRTHPLACE: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 522-03-1213
17. INFORMANT'S OWN SIGNATURE: Clara E. Kaattari ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5192

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypoxemia — ?
DUE TO (c) Acute Infection & Chronic Pulmonary disease — ?

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hemolytic anemia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-6, 1969, *to* 9/19, 1969, *that I last saw the deceased alive on* 9/19, 1969, *and that death occurred at* 9 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 752 MD
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 9/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/21/69
24c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: Oct 10/69
REGISTRAR'S SIGNATURE: Robert H. Wright per C.B.W.
25. EMBALMER: R. N. Mallard
LICENSE NO.: E-468

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bird Funeral Home Hailey, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 15 [illegible]

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 [illegible]6, inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4078
Local Reg. No. 30
Reg. Dist. No. 410

RECEIVED SEP 26 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
c. LENGTH OF STAY (in this place): 5 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blaine County Hospital 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
OTTO	LEMUEL	BROYLES	Sept. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Aug. 20, 1895	74	1	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Oakley, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alonzo Broyles	Indiana	MEITA LARANCE	Madison, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-09-2251
17. INFORMANT'S OWN SIGNATURE: X Theodore Broyle ADDRESS: Hailey, Idaho

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart dis — Generalized
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Abd aortic aneurysm & Partial renal shutdown — 2+ yrs,

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, 1969, *to* 9-22, 1969, *that I last saw the deceased alive on* 9-22, 1969, *and that death occurred at* 10:52 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wilbur W Parker MD	Hailey, Idaho	9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-25-1969	Hailey Masonic Cemetery	Hailey, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 24/69	Robert H. Wright	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev. U.S.N.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 11 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4079
Local Reg. No. 31
Reg. Dist. No. 410

RECEIVED STATE OF IDAHO

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Blaine 070 — OCT 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blaine Co. Hospital 037

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bellevue
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) ROY c. (Last) DENISON

4. DATE OF DEATH (Month) (Day) (Year): Sept. 23, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: April 2, 1894

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): contractor

10b. KIND OF BUSINESS OR INDUSTRY: building

11. BIRTHPLACE (State or foreign country): LaJara, Colo.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: W.E. (Buck) Denison — BIRTHPLACE: Tenn

14. MOTHER'S MAIDEN NAME: unk — BIRTHPLACE: unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 538-20-5185

17. INFORMANT'S OWN SIGNATURE: Curtis L. Denison — ADDRESS: Walnut Creek, Ca

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic emphysema
DUE TO (c) Peptic ulcer & hemorrhage

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-1, 1969, *to* Sept 23, 1969, *that I last saw the deceased alive on* Sept 23, 1969, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert H. Swinnerton MD (Degree or title)
23b. ADDRESS: Box 37 Hailey Idaho
23c. DATE SIGNED: 9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9/26/69
24c. NAME OF CEMETERY OR CREMATORY: Bellevue Cemetery
24d. LOCATION (City, town, or county) (State): Bellevue, Idaho

DATE REC'D BY LOCAL REG.: Sept 30/69
REGISTRAR'S SIGNATURE: Robert H. Wright, per B.H.
25. EMBALMER: Keith Bird — Keith Bird
LICENSE NO.: E-373
FIRM NAME: Bird Funeral Home Hailey

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

OCT 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4080
Local Reg. No. 34
Reg. Dist. No. 410

BIRTH NO.

RECEIVED
OCT 22 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clayton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Jess b. (Middle) L. c. (Last) Baker

4. DATE OF DEATH (Month) (Day) (Year): Sept. 29, 1969

5. SEX: Male

6. COLOR OR RACE: Wht.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Mar. 10, 1879

9. AGE (In years last birthday): 90
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 07

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Payette, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Elias Baker
BIRTHPLACE: Washington

14. MOTHER'S MAIDEN NAME: Anna Hall
BIRTHPLACE: Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-16-0733

17. INFORMANT'S OWN SIGNATURE: Ella Viola Berry
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro Vascular Thrombosis 4339
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/33, 1969, *to* 9/29, 1969, *that I last saw the deceased alive on* 9/29, 1969, *and that death occurred at* 9 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 752 (Degree or title): M.D.
23b. ADDRESS: Sun Valley, Idaho
23c. DATE SIGNED: 10-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Clayton Cemetery
24d. LOCATION (City, town, or county) (State): Clayton, Idaho

DATE REC'D BY LOCAL REG.: Oct. 20/69
REGISTRAR'S SIGNATURE: Robert W. Wright
25. EMBALMER: Keith Bird Kuobis
LICENSE NO.: E-373
FIRM NAME: Bird Funeral Home, Hailey, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021 Rev. Rev. 3-N

DUTIES:

JUL 18 1975

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 9 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4081
Local Reg. No. 352
Reg. Dist. No.

BIRTH NO. OCT 9 1969

1. PLACE OF DEATH
a. COUNTY Bureau of Vital Statistics Boise 080

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL - Pine Flats, 6 miles N. E. of Lowman

c. LENGTH OF STAY (In this place) Hours

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Boise 080

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Banks

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) CLAUDE
b. (Middle) H.
c. (Last) BENSON

4. DATE OF DEATH (Month) (Day) (Year) Sept. 25, 1969

5. SEX Male.

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH March 13, 1922

9. AGE (In years last birthday) 47

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logger 17

10b. KIND OF BUSINESS OR INDUSTRY Lumber

11. BIRTHPLACE (State or foreign country) Leadore, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry W. Benson
BIRTHPLACE Idaho

14. MOTHER'S MAIDEN NAME Ruth P. Barrow
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW II 4

16. SOCIAL SECURITY NO. 519-18-4921

17. INFORMANT'S OWN SIGNATURE Banks, Idaho
ADDRESS Mrs Claude Benson

928X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 8

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE 1 (Specify) Crushed by Logging Truck 11

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 080 (STATE) 6 Mi. N.E. of Lowman Boise, Co.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 25, 1969 8AM

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Never *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Richard H. Hanley 583 4 (Degree or title) Boise County Coronor

23b. ADDRESS Star Rt. Banks Idaho

23c. DATE SIGNED 10-6 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-29-69

24c. NAME OF CEMETERY OR CREMATORY Salmon Cemetery

24d. LOCATION (City, town, or county) (State) Salmon, Idaho

DATE REC'D BY LOCAL REG. 10/7/69

REGISTRAR'S SIGNATURE Henrietta Penrod

25. EMBALMER

LICENSE NO. E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 9 - 1969
OCT 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 6 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 10 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

MAR 20 1990

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4082
Local Reg. No. #92
Reg. Dist. No.

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
OCT 2 1969
Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 18 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Old Town

d. STREET ADDRESS (If rural, give location): Route 2, Box 22 A

3. NAME OF DECEASED (Type or Print)
a. (First): Clara
b. (Middle): Maude
c. (Last): Craig

4. DATE OF DEATH (Month) (Day) (Year): August 23, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 13, 1889
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Monroe Rose — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Emma Effie Eby — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 518 26 5647
17. INFORMANT'S OWN SIGNATURE: Thomas L. Craig — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5601

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure due to — INTERVAL BETWEEN ONSET AND DEATH: One-day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Paralytic Ileus and — 6-7 day
DUE TO (c) Electrolyte disturbance and

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe myocardial disease — 2 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 5, 1969, *to* Aug 23, 1969, *that I last saw the deceased alive on* Aug 23, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 471
23b. ADDRESS: [signature] Idaho
23c. DATE SIGNED: 9/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 9/30/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4083
Local Reg. No. #84
Reg. Dist. No.

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 040 Bonner SEP 11 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blanchard
Bureau of Vital Statistics
LENGTH OF STAY (in this place) 25 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blanchard
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ilmi	Ellen	Running	Sept 1 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Fe	White	Widowed	Nov 13 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew Johnson	Finland	Sophia Antilla	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	516 10 7580	May Sharp	Orofino, Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harry D. Nelson 533 Coroner	Sandpoint Idaho	9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/5/69	Blanchard Cemetery	Blanchard, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/10/69	Hale Anderson	C. E. Sherman	QL 155

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Sherman Funeral Home

DUTIES:

OCT 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 4 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4084
Local Reg. No. 183
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 034

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dover
d. STREET ADDRESS (If rural, give location): Box 32

3. NAME OF DECEASED (Type or Print)
a. (First): Emery
b. (Middle): Albert
c. (Last): McDorman

4. DATE OF DEATH (Month) (Day) (Year): September 2, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: March 10, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Aircraft
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert McDorman — BIRTHPLACE: Pennsylvania
14. MOTHER'S MAIDEN NAME: Rebecca Jane Simmons — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: unobtainable
17. INFORMANT'S OWN SIGNATURE: Mrs Maye Back — ADDRESS: Ventura Iowa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 29, 1969, *to* Sept 2, 1969, *that I last saw the deceased alive on* Sept 2, 1969, *and that death occurred at* 11:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Fred E Monenais (Degree or title) 307 MD
23b. ADDRESS: Sandpoint, Ida
23c. DATE SIGNED: 9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Memorial Park
24d. LOCATION (City, town, or county): Sandpoint (State): Idaho

DATE REC'D BY LOCAL REG.: 9/9/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

FIRM NAME: Moon Funeral Serviee

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 23 1973

OCT 26 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 21 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4085
Local Reg. No. #85
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 1 1 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint 200

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Priest River
d. STREET ADDRESS (If rural, give location): 68-D

3. NAME OF DECEASED (Type or Print)
a. (First): Alva
b. (Middle):
c. (Last): Houser

4. DATE OF DEATH (Month) (Day) (Year): September 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: June 2, 1906
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill worker 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Henry Houser — BIRTHPLACE: Pennsylvania
14. MOTHER'S MAIDEN NAME: Grace Anderson — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 518 18 9705
17. INFORMANT'S OWN SIGNATURE: + Owen F. Houser — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Depression

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Anoxia due to
DUE TO (c) Severe emphysema & Chronic Asthma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 21, 1963, *to* Sept 3, 1969, *that I last saw the deceased alive on* 1969, 1969, *and that death occurred at* 2:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]
23b. ADDRESS: [signature] 2 Idaho
23c. DATE SIGNED: 8/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Seneacquoteen Cemetery
24d. LOCATION (City, town, or county): Bonner County — (State): Idaho

DATE REC'D BY LOCAL REG.: 9/10/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4086
Local Reg. No. 19
Reg. Dist. No.

RECEIVED
OCT 2 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 09 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonner General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
d. STREET ADDRESS (If rural, give location) 606 Forest Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lola	Bell	Fury	September 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	October 27, 1890	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Mize	no record	no record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 38 4342	Renus O Fury	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4100 Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Recent myocardial infarction — 6 days
DUE TO (c) Coronary and Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Heart disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 19, 1961, *to* Sept 5, 1969, *that I last saw the deceased alive on* Sept 5, 1969, *and that death occurred at* 7:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lawyer Dunn #71	Sandpoint 9/29/69	9/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 8, 1969	Westmond Cemetery	Bonner County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/30/69	Hale Pederson	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4087
Local Reg. No. #87
Reg. Dist. No.

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 1 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 215 Forest

3. NAME OF DECEASED (Type or Print)
a. (First): Helene
b. (Middle): Wildfang
c. (Last): Davis

4. DATE OF DEATH (Month) (Day) (Year): Sept. 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept 8, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered nurse 13
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: H. P. C. Lasson — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Anna Wildfang — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 519 60 7877
17. INFORMANT'S OWN SIGNATURE: Eunice L. Peeks — ADDRESS: 215 Forest - Sandpoint

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b) Hemorrhage
DUE TO (c) Atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1958, *to* Sept, 1969, *that I last saw the deceased alive on* Sept 10, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Munson MD 382
23b. ADDRESS: Sandpoint Ida
23c. DATE SIGNED: 9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Broten Cemetery
24d. LOCATION (City, town, or county): Bonner County — (State): Idaho

DATE REC'D BY LOCAL REG.: 9/19/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4088
Local Reg. No. #86
Reg. Dist. No.

BIRTH NO.

RECEIVED STATE OF IDAHO

SEP 16 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bonner 09

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint

c. LENGTH OF STAY (In this place): 039

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bonner 090

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sagle

d. STREET ADDRESS (If rural, give location): Star Route

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Glenn	Vernon	Reed	September 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Sept 27, 1902	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Road construction

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert V. Reed — BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Eva Brown — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Glenn C. Reed — ADDRESS: 723 N. Boyer Sandpoint Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic carcinoma, right lung — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/21/68	Non-resectable carcinoma right lung	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Sept. 12, 1969, *that I last saw the deceased alive on* Sept. 11, 1969, *and that death occurred at* 6:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Helen Peterson M.D.	Sandpoint, Idaho	9/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial		Pinecrest Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/15/69	Dale Pederson	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 16 1969

APR 15 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4089
Local Reg. No. #88
Reg. Dist. No.

RECEIVED
SEP 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 1/2 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hope
d. STREET ADDRESS (If rural, give location): Box 216

3. NAME OF DECEASED (Type or Print)
a. (First): Earl
b. (Middle): nmn
c. (Last): Holly

4. DATE OF DEATH (Month) (Day) (Year): Sept 16, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 26, 1890
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paint contractor 21
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: No record — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W W I 3
16. SOCIAL SECURITY NO.: 518 34 5494
17. INFORMANT'S OWN SIGNATURE: Inez V Holly — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

552X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesenteric infection and irreversible ~~[illegible]~~ shock. — INTERVAL BETWEEN ONSET AND DEATH: 14 Hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Strangulated left inguinal hernia.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/15, 1969, *to* 9/16, 1969, *that I last saw the deceased alive on* 9/16, 1969, *and that death occurred at* 6500 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James R. Arthurs M.D. 900
23b. ADDRESS: 502 N 2ND. Sandpoint.
23c. DATE SIGNED: 9/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: Sept 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moon Crematory
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 9/25/69
REGISTRAR'S SIGNATURE: Dale Pederson
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 1 1983

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended February 16, 1970

Certificate of Death
STATE OF IDAHO

State File No. 4090
Local Reg. No. 89
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint 4
c. LENGTH OF STAY (In this place): 15 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 039 Bonner General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonner 09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kootenai
d. STREET ADDRESS (If rural, give location): Box 8

3. NAME OF DECEASED (Type or Print): a. (First) Clarence; b. (Middle) Muriel; c. (Last) Linscott

4. DATE OF DEATH (Month) (Day) (Year): September 17, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 21, 1908

9. AGE (In years last birthday): 61
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofing contractor 11

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence I. Linscott
BIRTHPLACE: Sparta, Wisconsin

14. MOTHER'S MAIDEN NAME: Emma LaFavor
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-05-3306

17. INFORMANT'S OWN SIGNATURE: Mrs. C. M. Linscott
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 20 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchial Asthma — 50 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 10, 19 53, *to* Sept 17, 19 69, *that I last saw the deceased alive on* Sept 17, 19 69, *and that death occurred at* 9:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE: John W. Smith, M.D. 480 (Degree or title) 1

23b. ADDRESS: Sandpoint, Idaho

23c. DATE SIGNED: 9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1

24b. DATE: Sept 20, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery

24d. LOCATION (City, town, or county) (State): Sandpoint, Idaho

DATE REC'D BY LOCAL REG.: 9-25-69

REGISTRAR'S SIGNATURE: Dale Pedersen

25. EMBALMER: Dale G. Coffelt

LICENSE NO.: E 501

FIRM NAME Moon Funeral Service

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
FEB 2 1970
Bureau of Vital Statistics

State of Idaho } ss.
County of Bonner }

Certificate No. 69-4090

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death for Clarence Muriel Linscott (Name on Original Certificate) who died (Was Born or Died) on Sept 17, 1969 (Birth or Death) (Date of Event) in Sandpoint, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by Bible Record (Bible Record, Insurance Policy, Etc.) prepared on early 1900's (Give Date) are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Fathers Birth Place	Minneapolis, Minnesota	Sparta, Wisconsin

Subscribed and sworn to before me this 29th day of January, 1970.

Charles E Anderson
Notary Public, residing at Sandpoint Ida
My commission expires Nov 1 1970
(Seal)

Signed: Juliano Linscott
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Kootenai Ida
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Bonner Idaho } ss.
County of Idaho Bonner }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 29th day of January, 1970.

Charles E Anderson
Notary Public, residing at Sandpoint Idaho
My commission expires November 1970
(Seal)

Signed: L L Moore Jr
(Signature of Any Credible Person)

Box 219 Sandpoint Idaho.
(Street Address, City, State)

FORM DH 60-155

2-1-70

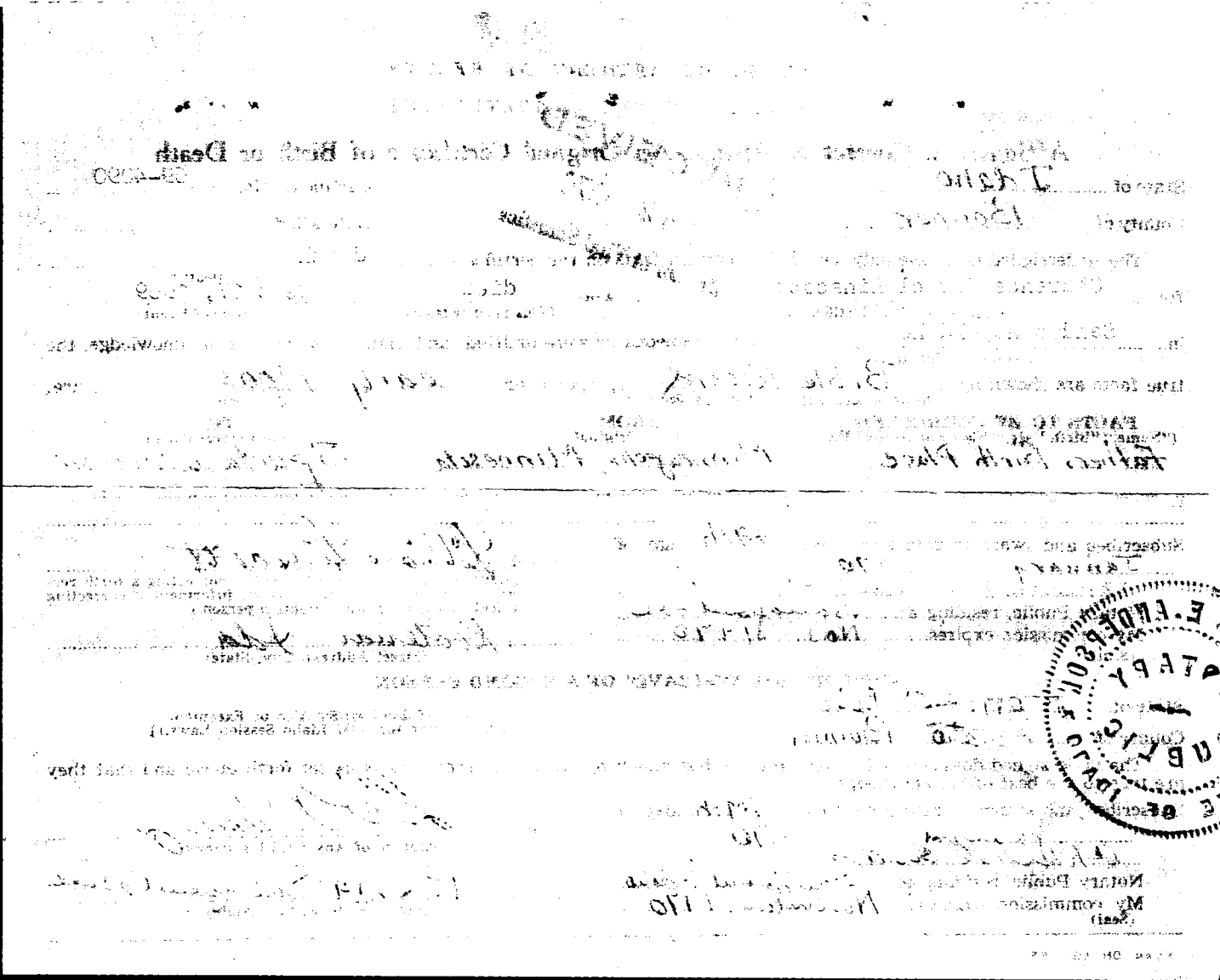

State File No. 4090
Local Reg. No. #89
Reg. Dist. No.

RECEIVED SEP 29 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 15 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kootenai
d. STREET ADDRESS (If rural, give location): Box 8

3. NAME OF DECEASED (Type or Print)
a. (First): Clarence
b. (Middle): Muriel
c. (Last): Linscott

4. DATE OF DEATH (Month) (Day) (Year): Sept. 17, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 21, 1908
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofing contractor 11
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): South Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence I. Linscott — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Emma LaFavor — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 518 05 3306
17. INFORMANT'S OWN SIGNATURE: X Mrs. C. M. Linscott — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 20 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchial Asthma — 50 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 10, 1953, *to* Sept 17, 1969, *that I last saw the deceased alive on* Sept 17, 1969, *and that death occurred at* 9:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: John W. Smith 480 (Degree or title) MD
23b. ADDRESS: Sandpoint, Ida
23c. DATE SIGNED: 9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county): Sandpoint (State): Idaho

DATE REC'D BY LOCAL REG.: 9/25/69
REGISTRAR'S SIGNATURE: Dale Pederson
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 28 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4091
Local Reg. No. #90
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 09 — SEP 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint — Burial
c. LENGTH OF STAY (in this place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 09
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 1224 Church Street

3. NAME OF DECEASED (Type or Print): a. (First) Minnie — b. (Middle) — c. (Last) Crosswhite

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 4, 1877

9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Haas — BIRTHPLACE: No record

14. MOTHER'S MAIDEN NAME: Margaret Welch — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 60 4873

17. INFORMANT'S OWN SIGNATURE: Edwin C Behrens — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Atherosclerosis

DUE TO (c) Generalized — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April 1956 *to* Sept 1969, *that I last saw the deceased alive on* Sept 18, 1969, *and that death occurred at* 3P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J Munson MD 332

23b. ADDRESS: Sandpoint Idy

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept 23, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 9/29/69

REGISTRAR'S SIGNATURE: Hale Cochran

25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4092
Local Reg. No. #93
Reg. Dist. No.

RECEIVED OCT 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 090
b. CITY OR TOWN: Sandpoint
LENGTH OF STAY (in this place): 12 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Residence 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN: Sandpoint
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Edna; b. (Middle) Marie; c. (Last) Licht

4. DATE OF DEATH (Month) (Day) (Year): Sept. 25, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 29, 1892

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: No record
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: No record
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: Unobtainable

17. INFORMANT'S OWN SIGNATURE: Mrs. B. L. Licht
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4409 Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1958 *to* Sept 1969, *that I last saw the deceased alive on* Sept 17, 1969, *and that death occurred at* 2:? m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. Munson MD (Degree or title)

23b. ADDRESS: Sandpoint Ida

23c. DATE SIGNED: 9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept 29, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 10/3/69

REGISTRAR'S SIGNATURE: Hale Addison

25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4093
Local Reg. No. 337
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 14 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (10)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 643

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville (10)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 167 West 14th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RALPH	R.	BROWN	Aug 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	August 13, 1899	70	0 / 4	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 28		Orient, Iowa	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Osman Baker Brown	Peedmont Ohio	Mattie Wilkins	Peedmont, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	480-16-1352	Naomi Brown by Leo A. Williams	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 492X Pulmonary heart disease. — INTERVAL BETWEEN ONSET AND DEATH: Several mos.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary emphysema. — Years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 6, 1969 *to* August 17, 1969 *that I last saw the deceased alive on* August 16, 1969 *and that death occurred at* 3:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L.K.Krantz, M.D.	798 South Boulevard Idaho Falls, Idaho	8-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug 20, 1969	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 9. 1969	Emma Rudger	Leo A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 17 196[illegible]

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4094
Local Reg. No. 297
Reg. Dist. No. 610

RECEIVED
Bureau of Vital Statistics
SEP 23 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 01 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 4 1/2 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LDS Extented Care Unit 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Iona
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) c. (Last) Conrad

4. DATE OF DEATH (Month) (Day) (Year) September 1 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 7, 1888

9. AGE (In years last birthday) 81

IF UNDER 1 YR. Months | Days

IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Iona, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Han L. Hansen
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Karen Marie Anderson
BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 44 9987D

17. INFORMANT'S OWN SIGNATURE Edith L Stephens
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac failure assoc pulmonary edem — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arterio-sclerosis. — 4years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Residual of Cerebral Hemorrhage. — 6 mos

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7, 1969, to 9-1, 1969, that I last saw the deceased alive on 9-1, 1969, and that death occurred at 5:30 P m., from the causes and on the date stated above.

23a. SIGNATURE Hoyt B. Woolley M.D. (Degree or title)

23b. ADDRESS 195 So Skyline Idaho Falls, Idaho

23c. DATE SIGNED 9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/4/69

24c. NAME OF CEMETERY OR CREMATORY Iona Cemetery

24d. LOCATION (City, town, or county) Iona Bonn. Co. (State) Idaho

DATE REC'D BY LOCAL REG. Sept 15, 1969

REGISTRAR'S SIGNATURE Anna Bradley

25. EMBALMER Ralph M. Wood Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4095
Local Reg. No. 330
Reg. Dist. No. 6/D

BIRTH NO.

RECEIVED
OCT 9 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Nursing Home 348

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
d. STREET ADDRESS (If rural, give location) none given

3. NAME OF DECEASED (Type or Print)
a. (First) ELIZABETH
b. (Middle) MAY
c. (Last) HARGIS

4. DATE OF DEATH (Month) (Day) (Year) Sept 2, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH May 11, 1892
9. AGE (In years last birthday) 77
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Hillsboro, Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Socrates Wood
BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Orpha Selecta Osborne
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 557-50-1181
17. INFORMANT'S OWN SIGNATURE X [signature] ADDRESS Ashton, Idaho

MEDICAL CERTIFICATION

4100

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive arteriosclerotic heart disease — 7 yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-17, 19 69, *to* 9-2, 1969, *that I last saw the deceased alive on* 9-2-69, 19___, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE X [signature] (Degree or title) 156
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 10-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Spet 5,1969
24c. NAME OF CEMETERY OR CREMATORY Pineview Cemetery
24d. LOCATION (City, town, or county) (State) Ashton, Idaho

DATE REC'D BY LOCAL REG. Oct 7-1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER [signature]
LICENSE NO. E-156
FIRM NAME Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 1 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4096
Local Reg. No. 2990
Reg. Dist. No. 610

BIRTH NO.

RECEIVED SEP 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Hospital (42)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 3750 No. Yellowstone Highway

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ned	M.	Houghton	September 2 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 1, 1898	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic (21)	Automotive Repair	Eureka, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eli Houghton	Utah	Sylvia Mandhart	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW 1, 3	560 10 7257A	Mrs Dieulieta F. Houghton	

18. CAUSE OF DEATH (1621)
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer of lung — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerotic heart

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan. , 19 67 to Sept 2 , 19 69 , that I last saw the deceased alive on Sept 2 , 19 69 , and that death occurred at 11:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron T. Weeks MD	1585 So. Boulevard	9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/5/69	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 15 '69	Irma Bridges	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 23 1969
SEP 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 23 1969
Bureau of Vital Statistics

State File No. 4097
Local Reg. No. 299
Reg. Dist. No. 611

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bonneville 100	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls	c. LENGTH OF STAY (In this place): Years
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 100	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 3 000	d. STREET ADDRESS (If rural, give location): Route # 3

3. NAME OF DECEASED (Type or Print)	a. (First): Henry	b. (Middle): Lee	c. (Last): Thomson	4. DATE OF DEATH (Month) (Day) (Year): September 2 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: February 10, 1891	9. AGE (In years last birthday): 78 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Andrew Thomson	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Mary Christina Steffenson	BIRTHPLACE: Denmark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 712 07 0451	17. INFORMANT'S OWN SIGNATURE: Mrs. Leora G. Thomson	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Gunshot (Self-Inflicted)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 2 Suicide	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Home 31	21c. (CITY, TOWN, OR TOWNSHIP): Taylor 100	(COUNTY): Bonne. (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Vernal C. Rydalch 383 (Degree or title): Corner	23b. ADDRESS: 3824 E. 17th Idaho Falls Idaho	23c. DATE SIGNED: 9-15-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9/5/69	24c. NAME OF CEMETERY OR CREMATORY: Lewisville Cemetery	24d. LOCATION (City, town, or county): Lewisville (State): Idaho
DATE REC'D BY LOCAL REG.: Sept. 19 '69	REGISTRAR'S SIGNATURE: Anna Bridges	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

OCT 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 29 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

State File No. 4098
Local Reg. No. 288
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (In this place) 3 1/2 Yrs	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Rest Home 348	d. STREET ADDRESS (If rural, give location) 1545 12th Street

3. NAME OF DECEASED (Type or Print)	a. (First) Charlotte	b. (Middle)	c. (Last) Decker	4. DATE OF DEATH (Month) (Day) (Year) September 3 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH October 29, 1880	9. AGE (In years last birthday) 88 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Ogden, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles C. Brown	BIRTHPLACE New York	14. MOTHER'S MAIDEN NAME Clara Armelia Leavitt	BIRTHPLACE Michigan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519 60 5970	17. INFORMANT'S OWN SIGNATURE Rex L. Decker	ADDRESS Idaho Falls	

5609

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) acute Bowel obstr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. marked generalized arteriosclerosis & senility.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Oct, 1964, *to* present, 19__, *that I last saw the deceased alive on* Aug 25, 1969, *and that death occurred at* 8:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title)	23b. ADDRESS 756 Oxford	23c. DATE SIGNED 9-3-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE 9/8/69	24c. NAME OF CEMETERY OR CREMATORY Ogden City Cemetery	24d. LOCATION (City, town, or county) Ogden (State) Utah
DATE REC'D BY LOCAL REG. Sept 5-1969	REGISTRAR'S SIGNATURE [signature]	25. EMBALMER Ralph M. Wood [signature]	LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4099
Local Reg. No. 306
Reg. Dist. No. 610

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville (10) — SEP 2 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls — LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Rest Home (348)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Bonneville (01)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Good Samaritan Rest Home

3. NAME OF DECEASED (Type or Print): a. (First) ADA — b. (Middle) MARIE — c. (Last) BOWMAN

4. DATE OF DEATH (Month) (Day) (Year): Sept, 4, 1969

5. SEX: Female

6. COLOR OR RACE: Whtie

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 16, 1881

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (0)

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Hova, Sweden

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Per Gustav Lind — BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Lovisa Anderson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Mrs. D. D. Grafe — ADDRESS: Ida. Falls, I

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Stroke — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Arterio sclosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-4- 68, *to* Sept. 4 69, *that I last saw the deceased alive on* Sept. 4, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton T. Rees M.D. — **23b. ADDRESS**: Idaho Falls, Ida — **23c. DATE SIGNED**: 9-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Sept. 9, 69 — **24c. NAME OF CEMETERY OR CREMATORY**: Rose Hill Cemetery — **24d. LOCATION** (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 19, 1969 — **REGISTRAR'S SIGNATURE**: Lenore Rudge

25. EMBALMER: Buck Sullivan — LICENSE NO.: E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 29 1969 Bureau of Vital Statistics

State File No. 4100
Local Reg. No. 307
Reg. Dist. No. 610

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 190 12th Street

3. NAME OF DECEASED (Type or Print): a. (First) Walter b. (Middle) Bernard c. (Last) Carlson

4. DATE OF DEATH (Month) (Day) (Year): September 4 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: November 6, 1915

9. AGE (In years last birthday): 53
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assistant Manager 08

10b. KIND OF BUSINESS OR INDUSTRY: Atomic Energy Com.

11. BIRTHPLACE (State or foreign country): Dorchester, Mass.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Nels Carlson
BIRTHPLACE: Mass.

14. MOTHER'S MAIDEN NAME: Alma Olson
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 540 12 0630

17. INFORMANT'S OWN SIGNATURE: Lolar M. Carlson
ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute myocardial impairment
INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Diabetes mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls Bonneville Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 27, 1969, *to* Sept. 4, 1969, *that I last saw the deceased alive on* Sept 3, 1969, *and that death occurred at* 7:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. K. Krantz, M.D.

23b. ADDRESS: 798 S. Blvd. Idaho Falls, Ida.

23c. DATE SIGNED: 9/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 9/9/69

24c. NAME OF CEMETERY OR CREMATORY: Toledo Cemetery

24d. LOCATION (City, town, or county) (State): Toledo Oregon

DATE REC'D BY LOCAL REG.: Sept 22 '69

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 3 0 1969
APR 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 2 1 1995
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

JUL 1 4 1977

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 23 1969

Bureau of Vital Statistics

State File No. 4101
Local Reg. No. 301
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ida ho Falls
c. LENGTH OF STAY (In this place): 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 440 East 24th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 440 East 24th Street

3. NAME OF DECEASED (Type or Print): a. (First) Charles; b. (Middle) Henry; c. (Last) Miller

4. DATE OF DEATH (Month) (Day) (Year): September 5 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: February 18, 1887

9. AGE (In years last birthday): 82
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Stockman

10b. KIND OF BUSINESS OR INDUSTRY: Farming & Stock

11. BIRTHPLACE (State or foreign country): Parker, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel G. Miller
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Helen Smith
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 10 9297

17. INFORMANT'S OWN SIGNATURE: Lon R. Miller
ADDRESS: Idaho Falls, Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: ½ hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 10 yrs
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-14, 1969, *to* 8-26-69, *that I last saw the deceased alive on* 8-26, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): X R Blair Edwards M.D.

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/9/69

24c. NAME OF CEMETERY OR CREMATORY: Parker Cemetery

24d. LOCATION (City, town, or county): Parker

(State): Idaho

DATE REC'D BY LOCAL REG.: Sept 15 '69

REGISTRAR'S SIGNATURE: Emma Rudgers

25. EMBALMER: Ralph M. Wood Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969
JUL 30 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4102
Local Reg. No. 294
Reg. Dist. No. 610

BIRTH NO. 69-8977

RECEIVED
SEP 16 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location): Route 3 Box 25

3. NAME OF DECEASED (Type or Print)	a. (First) DENNIS	b. (Middle) LYNN	c. (Last) SIMON	4. DATE OF DEATH (Month) (Day) (Year)		Sept 5, 1969
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): infant	8. DATE OF BIRTH: Sept 5, 1969	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours: 11 / Min.: 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknonn BIRTHPLACE		14. MOTHER'S MAIDEN NAME: Linda Simon BIRTHPLACE: Idaho Falls, Ida.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Reuben Simon	ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7777

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Prematurity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 1:40 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Frank R. Carey (Degree or title) 078 MD	23b. ADDRESS: Idaho Falls, Idaho	23c. DATE SIGNED: 9/8/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept 6, 1969	24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery	24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho
DATE REC'D BY LOCAL REG.: Sept. 11-69	REGISTRAR'S SIGNATURE: Irma Bridges	25. EMBALMER: Leo A. Williams	LICENSE NO.: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4103
Local Reg. No. 302
Reg. Dist. No. 610

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 — SEP 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give township): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27
b. COUNTY: Cascade 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Great Falls
d. STREET ADDRESS (If rural, give location): 1717 4th Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First): JESSIE
b. (Middle): W.
c. (Last): SNYDER

4. DATE OF DEATH (Month) (Day) (Year): Sept 6 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 2, 1881
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Spaulding Springs, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: C.A. Wedge — BIRTHPLACE: Unk
14. MOTHER'S MAIDEN NAME: Florence L. Herriott — BIRTHPLACE: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 517 58 7382
17. INFORMANT'S OWN SIGNATURE: Mrs. Florence Baldwin — ADDRESS: Grt. Fls, Mont.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5320

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage upper G.I. (Duodenal) — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Previous duodenal ulcers — years
~~DUE TO~~ (c) Parkinson Disease — years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes mellitus — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-14, 1969, *to* 9/6, 1969, *that I last saw the deceased alive on* 9-5, 1969, *and that death occurred at* 8 20 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hoyt B. Woolley M.D.
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 9/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 18, 69
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Bill Sullivan
LICENSE NO.: E387

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4104
Local Reg. No. 311
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
OCT 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Rest Home 348

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 338 Garfield St.

3. NAME OF DECEASED (Type or Print) a. (First) Clayton b. (Middle) Levi c. (Last) Crouse

4. DATE OF DEATH (Month) (Day) (Year) Sept 8, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Feb 29, 1884

9. AGE (In years last birthday) 85
IF UNDER 1 YR. Months 6 Days 11
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker 56

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Sparta, North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Solomon Crouse BIRTHPLACE *Sparta, North Carolina

14. MOTHER'S MAIDEN NAME Phoebe Higgins BIRTHPLACE *Sparta, N. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) War I 3

16. SOCIAL SECURITY NO. 4369

17. INFORMANT'S OWN SIGNATURE Lester P Crouse ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) C.V.A. Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arterio sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 18 69 *to* Sept. 8 69 *that I last saw the deceased alive on* September 8, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Milton T. Rees M.D.

23b. ADDRESS 148 N. Corner Ave

23c. DATE SIGNED 9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Sept. 11-1969

24c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery

24d. LOCATION (City, town, or county) Morrill, Nebraska (State)

DATE REC'D BY LOCAL REG. Sept. 27-69

REGISTRAR'S SIGNATURE Anna Budge

25. EMBALMER Leo A. Williams

LICENSE NO. D-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4105
Local Reg. No. 377
Reg. Dist. No. 6/D

RECEIVED
OCT 8 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ririe
d. STREET ADDRESS (If rural, give location): 410 1st West Street

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): ELIZABETH
c. (Last): DAVIS

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 8, 1969

5. SEX: Female

6. COLOR OR RACE: Whtie

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: November 23, 1921

9. AGE (In years last birthday): 47
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Ririe, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Head Davis
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Effie Walker
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 26 3418

17. INFORMANT'S OWN SIGNATURE: X Don McInnis
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Acute Cardiac Failure — 8 hrs

DUE TO (c): Rheumatic Heart Dis — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wendell L Nielsen MD
23b. ADDRESS:
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 11, 69
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 1-1969
REGISTRAR'S SIGNATURE: Anna Budge
25. EMBALMER: Bill Sullivan
LICENSE NO.: E387

FIRM NAME: Book-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED OCT 9 1969 Bureau of Vital Statistics

State File No. 4106
Local Reg. No. 324
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bonneville	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls — c. LENGTH OF STAY (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital	d. STREET ADDRESS (If rural, give location): 503 West 19th Street

3. NAME OF DECEASED (Type or Print) a. (First): William	b. (Middle): R.	c. (Last): Rutz	4. DATE OF DEATH (Month) (Day) (Year): September 8 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: May 30, 1892	9. AGE (In years last birthday): 77 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Businessman	10b. KIND OF BUSINESS OR INDUSTRY: Fabric Shop	11. BIRTHPLACE (State or foreign country): Racine, Wisconsin	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Julius Rutz	BIRTHPLACE: USA	14. MOTHER'S MAIDEN NAME: Mary	BIRTHPLACE: USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 540 05 0408	17. INFORMANT'S OWN SIGNATURE: Mary E. Rutz	ADDRESS: Idaho Falls, Ida.	

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Q-S N D — INTERVAL BETWEEN ONSET AND DEATH: 18 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls Bonneville Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* May 9, *19* 68, *to* Sept. 8, *19* 69, *that I last saw the deceased alive on* 7 Sept, *19* 69, *and that death occurred at* 3:40a. *m., from the causes and on the date stated above.*

23a. SIGNATURE: L. K. Krantz (294) (Degree or title): L. K. Krantz, M. D.	23b. ADDRESS: 798 S. Blvd. Idaho Falls, Ida.	23c. DATE SIGNED: 9/16/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9/11/69	24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho
DATE REC'D BY LOCAL REG.: Oct. 7-'69	REGISTRAR'S SIGNATURE: Anna Bridges	25. EMBALMER: Ralph M. Wood	LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 1 1 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4107
Local Reg. No. 308
Reg. Dist. No. 610

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville (01) SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho
LENGTH OF STAY (in this place) 1yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 965 Westergard (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville (101)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1055 Woodruff

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GREGORY	SCOTT	GOLDEN	Sept. 10, 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	Jan. 13, 1966	3				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None (02)	None	Milwaukee, Wis	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ralph Willard Golden	Wisc.	Mary Jane Sethre	N. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Ralph W. Golden	Ga. Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9139 Suffocation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 965 Westergard (000)
21c. (CITY, TOWN, OR TOWNSHIP) Idaho Falls (3101) (COUNTY) Bonneville (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vernal Rydalch (583)	Coroner	5824 E 17th	9-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal (3)	Sept 12, 1969	Superior, Wisc. Cemetery	Superior, Wisconsin

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 22-69	Anna Burgess	Bice Sullivan	E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4108
Local Reg. No. 303
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville (10) SEP 2 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
LENGTH OF STAY (In this place) 27 Dyx
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 005
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley, Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Tressa	Amilita	Hunter	Sept	10	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Jan 23 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Sanpete County Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Redick Redin Allred --	Pottawattmie, Iowa	Eliza E. Allred	Spring City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	519-16-4357	Leylani B Hunter	1570 Cassiopeia Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 2 d

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 9, 1969, to Sept 10, 1969, *that I last saw the deceased alive on* Sept 10, 1969, *and that death occurred at* 12:05 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron C. Weeks MD	1585 So. Boulevard	9-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 13-69	Hill Crest	Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 19-1969	Verna Bridges	Floyd M. Walden	E 275

FIRM NAME: Walden's Funeral Home. Shelley, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-10017

BIRTH NO.

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 23 1969 Bureau of Vital Statistics

State File No. 4109
Local Reg. No. 305
Reg. Dist. No. 610

1. PLACE OF DEATH
a. COUNTY: Bonneville (07)
b. CITY OR TOWN: Idaho Falls
c. STAY (in this place): 5 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 342

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton 40
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
d. STREET ADDRESS (If rural, give location): rural

3. NAME OF DECEASED (Type or Print)
a. (First): Darren
b. (Middle): Ray
c. (Last): Johnsen

4. DATE OF DEATH: (Month) (Day) (Year): Sept 10, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Sept 10, 1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours: 5 | Min.: 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 02

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Terryl Johnson
BIRTHPLACE: Driggs, Idaho

14. MOTHER'S MAIDEN NAME: Alice Marie Tarbot
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: * Terryl E Johnson
ADDRESS: Driggs, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Diabetes Mellitus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Anoxia, Chronic
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert Johnson M.D. (Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept 13, 1969

24c. NAME OF CEMETERY OR CREMATORY: Cache-Clawson Cemetery

24d. LOCATION (City, town, or county) (State): near Tetonia, Idaho

DATE REC'D BY LOCAL REG.: Sept 17-69

REGISTRAR'S SIGNATURE: Anna Rudges

25. EMBALMER: Robert Bean

LICENSE NO.: E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63022

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4110
Local Reg. No. 304
Reg. Dist. No. 610

BIRTH NO.

RECEIVED SEP 23 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY in this place: 3 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 965 Westergard (002)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville (01)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 965 Westergard

3. NAME OF DECEASED (Type or Print): a. (First) MARK b. (Middle) ALEXANDER c. (Last) KINGHORN

4. DATE OF DEATH (Month) (Day) (Year): Sept. 10, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: Jan. 31, 1965

9. AGE (In years last birthday): 4 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child (02)

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Bakersfield, California.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Doyle Kinghorn — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Lynn Parshall — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: X

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: 965 Westergard Idaho Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 9139 Suffocation

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home (28)

21c. (CITY, TOWN, OR TOWNSHIP) (13101) (COUNTY) (STATE): Idaho Falls Bonneville Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 10 69 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Closed in Refrigerator.

22. *I hereby certify that* [illegible] *that I last saw the deceased* [illegible] *alive on* [illegible] *that death occurred at* 5:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Verna Bydalek (553) (Degree or title): coroner

23b. ADDRESS: Idaho Falls, Idaho.

23c. DATE SIGNED: Sept 13, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept.13,1969

24c. NAME OF CEMETERY OR CREMATORY: Lewisville

24d. LOCATION (City, town, or county) (State): Lewisville Jefferson Idaho

DATE REC'D BY LOCAL REG.: Sept. 19-69

REGISTRAR'S SIGNATURE: Verna Bydalek

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-630-21

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4111
Local Reg. No. 375
Reg. Dist. No. 611

BIRTH NO.

RECEIVED OCT 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Tin Cup
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Tin Cup Area

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1072 Halsey Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	A.	Robinson	September 13 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 28, 1923	46		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Security Officer 08	Atomic Energy Com.	Burley, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John S. Robinson	Ind.	Violet Allen	Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 4	51910 9346	Teresa Robinson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Heart disease — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from March, 19 63, to 17 Sept, 19 69, that I last saw the deceased alive on 16 July, 19 69, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D C Hollard MD Coroner	Idaho Falls, Idaho	22 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/19/69	Grandview Cemetery	Burley Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 27-1969	Anna Rudger	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1969
OCT 7 1969
JUL 15 1983
DEC 22 1986

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
OCT 8 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4112
Local Reg. No. 378
Reg. Dist. No. 610

BIRTH NO. 69-9004

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 072

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 134 So. Clark

3. NAME OF DECEASED (Type or Print): a. (First) NOE b. (Middle) CORTEZ c. (Last) Jr.

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 14, 1969

5. SEX: Male

6. COLOR OR RACE: Mex.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: Sep.14,1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours 5 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Noe Cortez — BIRTHPLACE: McCallen, Texas

14. MOTHER'S MAIDEN NAME: Sandy McBride — BIRTHPLACE: Worland, Wyoming.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Noe Cortez — ADDRESS: Rigby, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7763

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Respiratory Distress — INTERVAL BETWEEN ONSET AND DEATH: 5 Hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Prematurity

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: none performed

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 14 Sept., 1969, *to* 14 Sept., 1969, *that I last saw the deceased alive on* 14 Sept., 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Tall 572 — (Degree or title): M.D. — **23b. ADDRESS**: Rigby, Idaho. — **23c. DATE SIGNED**: 19 Sept. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Sep. 19,1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Lewisville — **24d. LOCATION** (City, town, or county) (State): Lewisville Jefferson Ida.

DATE REC'D BY LOCAL REG.: Oct. 1 '69 — REGISTRAR'S SIGNATURE: Emma Rudges

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: Bruce A. Eckersell E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

I, Noe Cortez, being the father of Noe Cortez Jr., who id also the son of Sandy McBride Cuevas do respectfully request the name of Noe Cortez Jr. be placed on the certificate of death and that my name be listed as the legal father.

Noe Cortez

Noe Cortez

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 8 1969 Bureau of Vital Statistics

State File No. 4113
Local Reg. No. 327
Reg. Dist. No. 6/6

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ririe
d. STREET ADDRESS (If rural, give location) 280 West Smith

3. NAME OF DECEASED (Type or Print) a. (First) Eleanore b. (Middle) c. (Last) Mason

4. DATE OF DEATH (Month) (Day) (Year) September 14 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 3, 1890

9. AGE (In years last birthday) 79
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Johnson's Fort Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph S. Armstrong
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Sussanah Dalley
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Eleanore Mason
ADDRESS Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2070

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) acute leukemia
INTERVAL BETWEEN ONSET AND DEATH 4 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 24, 1969, to Sept 14, 1969, that I last saw the deceased alive on Sept 13, 1969, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE Byron T Weeks 556 (Degree or title) MD

23b. ADDRESS 1585 So Boulevard

23c. DATE SIGNED 9-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/17/69

24c. NAME OF CEMETERY OR CREMATORY Ririe Shelton Cemetery

24d. LOCATION (City, town, or county) Ririe (State) Idaho

DATE REC'D BY LOCAL REG. Sept 30 '69

REGISTRAR'S SIGNATURE Emma Burgess

25. EMBALMER Ralph M. Wood Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
SEP 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4114
Local Reg. No. 309
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (in this place) 1 mon.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby
d. STREET ADDRESS (If rural, give location) Box 282

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HAROLD	THOMAS	PROPHET	Sept. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Sept 13, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bar Tender 23	Bar	Rigby, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David D. Prophet	Centerville, Ut.	Lillian May Saxton	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	539-10-8452	Walt S Prophet	Box 282 Rigby, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1890

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) RENAL CARCINOMA c — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) METASTASES
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
PATHOLOGIC FRACTURES Rt HUMERUS & L KNEE

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
at Mayos	Biopsy - metastatic Ca to bone	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 18, 1969, *to* Sep. 15, 1969, *that I last saw the deceased alive on* Sep. 15, 1969, *and that death occurred at* 6:45P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	Idaho Falls, Idaho.	Sep. 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial,	Sept. 18, 69	Rigby Pioneer	Rigby Jefferson Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22-69	Anna Rudges	Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4115
Local Reg. No. 37
Reg. Dist. No. 6

BIRTH NO.

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (02)
OCT 2 1969
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Iona
c. LENGTH OF STAY (In this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 127 S 3rd (OW)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Iona (02)
d. STREET ADDRESS (If rural, give location): 127 S 3rd

3. NAME OF DECEASED (Type or Print): a. (First) Max b. (Middle) W. c. (Last) Steele

4. DATE OF DEATH (Month) (Day) (Year): September 15 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 14, 1912

9. AGE (In years last birthday): 57
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Master Blacksmith (10)

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Iona, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John R. Steele
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mytrle Waldram
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 09 1004

17. INFORMANT'S OWN SIGNATURE: Erma Steele
ADDRESS: Iona, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

"This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastasis to brain — INTERVAL BETWEEN ONSET AND DEATH: weeks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ca body Vertebrae
DUE TO (c) Carcinoma prostate — 3 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia Bronchial — 1 week

1857

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1906 *to* 15 Sept 1969 *that I last saw the deceased alive on* 15 Sept 1969 *and that death occurred at* 4 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M. Hall MD

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: 20 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/18/69

24c. NAME OF CEMETERY OR CREMATORY: Iona Cemetery

24d. LOCATION (City, town, or county) (State): Iona Idaho

DATE REC'D BY LOCAL REG.: Sept 25, 1969

REGISTRAR'S SIGNATURE: Erma Bruce

25. EMBALMER: Ralph M. Wood Ralph M Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 3 1969

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 24 1990
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. MAR 19 2007
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 2 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4116
Local Reg. No. 370
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mackay
d. STREET ADDRESS (If rural, give location): 608 Elm

3. NAME OF DECEASED (Type or Print): a. (First) EDWARD; b. (Middle) GLENN; c. (Last) PENCE

4. DATE OF DEATH (Month) (Day) (Year): September 16, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 18, 1897

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 32

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Yard

11. BIRTHPLACE (State or foreign country): Barton, Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James R. Pence
BIRTHPLACE: Lomax, Illinois

14. MOTHER'S MAIDEN NAME: Catherine Bradshaw
BIRTHPLACE: Gallatin Valley, Mont.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W. W. I 3

16. SOCIAL SECURITY NO.: 518-07-4697

17. INFORMANT'S OWN SIGNATURE: Mrs. E. Glenn Pence
ADDRESS: Mackay, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchopneumonia 485X
INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Hypertensive Heart Disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Ruptured abdominal aortic aneurysm
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-5, 1969, *to* 9/16, 1969, *that I last saw the deceased alive on* 9-16, 1969, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: 1955 So 3rd Idaho Falls Idaho
23c. DATE SIGNED: 9/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-19-69
24c. NAME OF CEMETERY OR CREMATORY: Mt. McCaleb
24d. LOCATION (City, town, or county) (State): Mackay, Idaho

DATE REC'D BY LOCAL REG.: Sept. 26-69
REGISTRAR'S SIGNATURE: Anna Rudger
25. EMBALMER:
LICENSE NO.: E-457
FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: OCT 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4117
Local Reg. No. 314
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 2 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 289 Balsam Circle

3. NAME OF DECEASED (Type or Print): a. (First) Donna; b. (Middle) Jean; c. (Last) Rasmussen

4. DATE OF DEATH (Month) (Day) (Year): September 16 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	May 18, 1926	43		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albern Cook	Utah	Barbara Wright	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Not Available	Donna Rasmussen	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 2509

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Diabetic acidosis - chronic nephritis - cerebral arteriosclerosis

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. H. Baker M.D.	Idaho Falls	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/19/69	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 27-'69	Anna Burgess	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JUN 0 1 2000

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4118
Local Reg. No. 315
Reg. Dist. No. 6/D

BIRTH NO.

RECEIVED OCT 2 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 475 L Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Rhoda		Jardine	September 17 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	January 1, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Annis, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
N Christian Geisler	Denmark	Frances K. Lowder	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 30 8346-D	Frances K. Jardine	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Hemorrhage	Weeks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertensive Cardio Vascular disease	several years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 28 1968 *to* 17 Sept, 1969, *that I last saw the deceased alive on* 17 Sept, 1969, *and that death occurred at* 6 Hrs. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D Stoddard MD	Idaho Falls, Idaho	22 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/20/69	Lewisville Cemetery	Lewisville Jefferson Co. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 27-1969	Anna Rudgren	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4119
Local Reg. No. 334
Reg. Dist. No. 610

BIRTH NO.

OCT 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 23 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Roberts,
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First): Anna	b. (Middle): Jane	c. (Last): Rossback	4. DATE OF DEATH (Month) (Day) (Year): September 17 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: December 27, 1884	9. AGE (In years last birthday): 84 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: David Whitlatch	BIRTHPLACE: Virginia	14. MOTHER'S MAIDEN NAME: Phoebe Boyer	BIRTHPLACE: USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518 18 5583D	17. INFORMANT'S OWN SIGNATURE: ✓ Ann Taylor	ADDRESS: Idaho Falls, Id	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

404X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): ① Cardio Vascular Renal

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Disease ~~[illegible]~~

DUE TO (c): ② Uremia (Cause of Death)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Yrs. 6 Wks.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 21, 1960, *to* September 17, 1969, *that I last saw the deceased alive on* Sept 17 1969, *and that death occurred at* 9:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: D W Corbett 104 (Degree or title) MD	23b. ADDRESS: 798 South Boulevard Idaho Falls, Idaho	23c. DATE SIGNED: 10/11/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9/20/69	24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park	24d. LOCATION (City, town, or county): Idaho Falls (State): Idaho
DATE REC'D BY LOCAL REG.: Oct. 11-'69	REGISTRAR'S SIGNATURE: Anna Bridges	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 14 19

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4120
Local Reg. No. 325
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY IN THIS PLACE 80 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 130 West 18th Street

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) c. (Last) Priest

4. DATE OF DEATH (Month) (Day) (Year) September 18 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH October 24, 1882

9. AGE (In years last birthday) 86
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Polli, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Skyles
BIRTHPLACE USA

14. MOTHER'S MAIDEN NAME Bardney Johnson
BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 22 2325

17. INFORMANT'S OWN SIGNATURE F Francis Priest
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis
INTERVAL BETWEEN ONSET AND DEATH 6/28/69

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 9, 1966 *to* September 18, 1969 *that I last saw the deceased alive on* Sept 17, 1969 *and that death occurred at* 9:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE C. F. Francis M.D. (Degree or title)

23b. ADDRESS 798 South Boulevard Idaho Falls, Idaho

23c. DATE SIGNED 9/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/22/69

24c. NAME OF CEMETERY OR CREMATORY Taylor Cemetery

24d. LOCATION (City, town, or county) (State) Taylor Bonneville Co. Idaho

DATE REC'D BY LOCAL REG. Oct. 7-1969

REGISTRAR'S SIGNATURE Lena Rudges

25. EMBALMER Ralph M. Wood Ralph M. Wood
LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4121
Local Reg. No. 319
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (In this place) 30yrs	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred heart Hospital 043	d. STREET ADDRESS (If rural, give location) 356 South Water Ave.

3. NAME OF DECEASED (Type or Print) a. (First) CARL	b. (Middle) OSCAR	c. (Last) BACKSTROM	4. DATE OF DEATH (Month) (Day) (Year) Sept. 19, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 14, 1894	9. AGE (In years last birthday) 74 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21	10b. KIND OF BUSINESS OR INDUSTRY Auto	11. BIRTHPLACE (State or foreign country) Moorhead, Minnesota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Backstrom,	BIRTHPLACE Sweden	14. MOTHER'S MAIDEN NAME Hilma Olson	BIRTHPLACE Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI 3	16. SOCIAL SECURITY NO. 518 16 6346A	17. INFORMANT'S OWN SIGNATURE Mrs Carl O. Backstrom	ADDRESS	

4319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebro Vascular	48 hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Accident probably hemorrhage	
DUE TO (c)	Arteriosclerosis generalized	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerebral arteriosclerosis & senility & Cardio vascular renal disease	10 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) Idaho Falls,	(COUNTY) Bonneville (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* October 24, 1955, *to* September 19, 1969, *that I last saw the deceased alive on* September 19, 1969, *and that death occurred at* 11:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE G. W. Corbett, M.D. 104 (Degree or title)	23b. ADDRESS 798 South Boulevard Idaho Falls, Idaho	23c. DATE SIGNED 9/26/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 23, 69	24c. NAME OF CEMETERY OR CREMATORY Fielding Mem. Cem.	24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho
DATE REC'D BY LOCAL REG. Oct. 1-1969	REGISTRAR'S SIGNATURE Anna Bridger	25. EMBALMER Bill Sussman	LICENSE NO. E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 0 1969

OCT 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4122
Local Reg. No. 386
Reg. Dist. No. 610

RECEIVED OCT 2 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY (or) Bonneville
b. CITY OR TOWN Idaho Falls
STAY (in this place) 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) 51 So. 1 West

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) Edward
c. (Last) Blake

4. DATE OF DEATH (Month) Sept. (Day) 19, (Year) 1969

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Nov. 8, 1892
9. AGE (In years last birthday) 76
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SD
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ira, Cayuga Co., New York
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William J. Blake
BIRTHPLACE Hannibal, New York
14. MOTHER'S MAIDEN NAME Clara Corporn
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) World War 1
16. SOCIAL SECURITY NO. 529-01-8635A
17. INFORMANT'S OWN SIGNATURE Margaret A. Stephenson
ADDRESS Rexburg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction
INTERVAL BETWEEN ONSET AND DEATH Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Benign Prostatic Hypertrophy

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* 9-17, 1969, *to* 9-19, 1969 *that I last saw the deceased alive on* 9-19, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 546
23b. ADDRESS Idaho Falls, Ida
23c. DATE SIGNED 9/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/23/69
24c. NAME OF CEMETERY OR CREMATORY Mountain View
24d. LOCATION (City, town, or county) Pocatello, Bannock, Idaho (State)

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
25. EMBALMER Russell Adamson
LICENSE NO. E-254

FIRM NAME: Adamson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4123
Local Reg. No. 376
Reg. Dist. No. 61

BIRTH NO.

RECEIVED
OCT 2 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, R#4
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, R#4
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle) Blaine
c. (Last) Rumsey

4. DATE OF DEATH (Month) (Day) (Year) Sept 21 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 25 1912
9. AGE (In years last birthday) 57
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rigby, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME George A Rumsey -- BIRTHPLACE Malad Idaho
14. MOTHER'S MAIDEN NAME Edith Chiles -- BIRTHPLACE Salina, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-14-1296
17. INFORMANT'S OWN SIGNATURE Darlene R. Anderson ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1990

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Extensive metastatic undifferentiated cell carcinoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE D. H. Baker 018 (Degree or title) M.D.
23b. ADDRESS Idaho Falls
23c. DATE SIGNED 9.24.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9 24- 1969
24c. NAME OF CEMETERY OR CREMATORY Fielding Memorial
24d. LOCATION (City, town, or county) (State) Idaho Falls, Bonneville, Idaho

DATE REC'D BY LOCAL REG. Sept. 27- '69
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Lloyd M Nalder
LICENSE NO. E 275

FIRM NAME: Nalder's Funeral Home Shelley, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1969
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DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4124
Local Reg. No. 326
Reg. Dist. No. 670

BIRTH NO. 69-9039

RECEIVED OCT 9 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 6 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route # 1 Box 370

3. NAME OF DECEASED (Type or Print): a. (First) Steven; b. (Middle) Paul; c. (Last) Johnson

4. DATE OF DEATH: (Month) September (Day) 22 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: September 22, 1969

9. AGE (In years last birthday): IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min. 6

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Tebbin G. Johnson
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Mary Larue Jenkins
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Tebbin G Johnson
ADDRESS: Rt 1, Box 370 Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Prematurity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rh Sensetization
DUE TO (c) Placental Insufficiency

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 9/22/69

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/22, 1969 to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] M.D. (Degree or title)

23b. ADDRESS: 2065 E 17th St

23c. DATE SIGNED: 10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/25/69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county): Idaho Falls (State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 7-1969

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Ralph M. Wood [signature]

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4125
Local Reg. No. 323
Reg. Dist. No. 610

RECEIVED OCT 9 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY (101) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
STAY (in this place) 14 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital (042)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls (100)
d. STREET ADDRESS (If rural, give location) Rte. #2 (Lincoln)

3. NAME OF DECEASED (Type or Print) a. (First) JANET b. (Middle) c. (Last) TREMELLING

4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Oct. 15, 1882

9. AGE (In years last birthday) 86
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker (01)

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) St. George, Utah.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Don Carlos Ribbons
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Wilhelmina Gray
BIRTHPLACE Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-42-7535

17. INFORMANT'S OWN SIGNATURE Jesse Tremelling ADDRESS Idaho Falls Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — Years
DUE TO (c) Arteriosclerosis & Hypertension — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION none performed

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. *, 19*49*, to* Sept. 24*, 19*69*, that I last saw the deceased alive on* Sept. 24*, 19*69*, and that death occurred at* 8:48A *m., from the causes and on the date stated above.*

23a. SIGNATURE Asael Tall, M.D. (Degree or title)

23b. ADDRESS Rigby, Idaho.

23c. DATE SIGNED 27 Sept. 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sep. 27, 1969

24c. NAME OF CEMETERY OR CREMATORY Little Butte

24d. LOCATION (City, town, or county) (State) Annis Jefferson Idaho.

DATE REC'D BY LOCAL REG. Oct. 6, 1969

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER Bruce A. Eckersell
LICENSE NO. E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4126
Local Reg. No. 335
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED
OCT 14 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY (101) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital (042)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville (100)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) Route 4

3. NAME OF DECEASED (Type or Print) a. (First) Raymond b. (Middle) n c. (Last) Carney

4. DATE OF DEATH (Month) (Day) (Year) Sept 25, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH July 25, 1898

9. AGE (In years last birthday) 71
IF UNDER 1 YR. Months 1 Days 27
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher and farmer (12)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Prairie GroveArkansas

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Estes I Ed) Carney BIRTHPLACE *Fayetteville, Ark.

14. MOTHER'S MAIDEN NAME Carrie Spradlin BIRTHPLACE *Selvin, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Louis Carney ADDRESS Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral vascular accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Decubitus
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 10 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-13-, 19 69 *to* 9-25-, 19 69, *that I last saw the deceased alive on* 9-25-, 19 69 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE John S Hatch 210 M D (Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/29/69

24c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery

24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Oct. 9-1969

REGISTRAR'S SIGNATURE Anna Rudges

25. EMBALMER Leo A. Williams

LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4127
Local Reg. No. 327
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED
OCT 9 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital (42)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 925 8th Street

3. NAME OF DECEASED (Type or Print): a. (First) Joseph b. (Middle) Clyde c. (Last) Merkley

4. DATE OF DEATH: (Month) (Day) (Year) September 26 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: September 20, 1914

9. AGE (In years last birthday): 55
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Businessman (22)

10b. KIND OF BUSINESS OR INDUSTRY: Auto Parts

11. BIRTHPLACE (State or foreign country): Logan, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathaniel W. Merkley
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Myrtle Quinney
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 528 09 3592

17. INFORMANT'S OWN SIGNATURE: Mozella Merkley
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia Lobar — hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastatic Carcinoma — 1 year
DUE TO (c) Carcinoma of Stomach — 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1967 *to* Sept, 1969, *that I last saw the deceased alive on* Sept, 1969, *and that death occurred at* 1.30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Joseph M Nebeker MD (Degree or title)

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal (3)

24b. DATE: 9/29/69

24c. NAME OF CEMETERY OR CREMATORY: Logan Cemetery

24d. LOCATION (City, town, or county) (State): Logan Utah

DATE REC'D BY LOCAL REG.: Oct. 7-1969

REGISTRAR'S SIGNATURE: Anna Budge

25. EMBALMER: Ralph M. Wood Ralph M Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 21 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4128
Local Reg. No. 320
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
d. STREET ADDRESS (If rural, give location): 684 East 15th St.

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): WINIFRED LOUISE GULICK

4. DATE OF DEATH (Month) (Day) (Year): Sept 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 1, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Soda Springs, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Christopher Taylor Woodall, BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Ellen Doyle, BIRTHPLACE: MIssouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 40 2564 B
17. INFORMANT'S OWN SIGNATURE: Joseph I. Gulick — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 21, *19*62, *to* 28 Sept, *19*69, *that I last saw the deceased alive on* 27 Sept, *19*69, *and that death occurred at* 10:20A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. T. Kranz MD 294
23b. ADDRESS: 798 South Boulevard, Idaho Falls, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Sept. 30, 69
24c. NAME OF CEMETERY OR CREMATORY: Soda Springs Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REGD: Oct 15-69
REGISTRAR'S SIGNATURE: Anna Bredger
25. EMBALMER: Buck Sullivan
LICENSE NO.: E 387

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

JAN 23 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4129
Local Reg. No. 322
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 33 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 700
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Nursing Center 348	d. STREET ADDRESS (If rural, give location): Route # 3 Box 81

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thomas	Lorenzo	Nixon	September 28 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
Male	White	Widowed	April 2,1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Potato Company	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas A. Nixon	Utah	Emma Jane Catmull	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 60 6394T	Ruth Jennings	Idaho Falls, Idaho

188X

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	PELVIC ABSCESS	4 mo
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	COBALT THERAPY	9 mo
DUE TO (c)	TRANSITIONAL CELL CA BLADDER	6 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	ABSCESS OF LF THIGH	4 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-10-69	MASSIVE PELVIC ADHESIONS	Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-26, 1969, *to* 9-28, 1969, *that I last saw the deceased alive on* 9-28, 1969, *and that death occurred at* 400 *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] MD 430 (Degree or title)	1176 E 17th IDAHO FALLS IDA.	9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/1/69	Iona Cemetery	Iona Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 2 -69	[signature]	Ralph M. Wood [signature]	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4130
Local Reg. No. 328
Reg. Dist. No. 610

BIRTH NO. 69-9060

RECEIVED OCT 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (In this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 400 S Street

3. NAME OF DECEASED (Type or Print): a. (First) Bret b. (Middle) Marvin c. (Last) Ross

4. DATE OF DEATH (Month) (Day) (Year): September 28 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: September 28, 1969

9. AGE (In years last birthday): 22
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Marvin H. Ross
BIRTHPLACE: California

14. MOTHER'S MAIDEN NAME: Eva Lou Romrell
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Marvin H. Ross
ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7708

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Prematurity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) premature rupture of membrane
DUE TO (c) placenta circumvallate

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-28 19 69 *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 3:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Rulon D. Robertson MD

23b. ADDRESS: 1065 E 12th

23c. DATE SIGNED: 10-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/30/69

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Oct. 7-1969

REGISTRAR'S SIGNATURE: Lenore Bridges

25. EMBALMER: Ralph M. Wood Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4131
Local Reg. No. 329
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
OCT 9 1969

1. PLACE OF DEATH
a. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Hospital (42)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville (00)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby
d. STREET ADDRESS (If rural, give location) Route # 2 Box 57

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Henry c. (Last) Andersen

4. DATE OF DEATH (Month) (Day) (Year) September 30 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH November 7, 1892

9. AGE (In years last birthday) 76
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Teacher (12)

10b. KIND OF BUSINESS OR INDUSTRY Farming & School

11. BIRTHPLACE (State or foreign country) Benjamin, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Andersen
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Nora Cutler
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 07 6539

17. INFORMANT'S OWN SIGNATURE Lloyd O. Andersen
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 5320 Massive Hemorrhage Duodenal Ulcer — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Arthritis - Rheumatoid — 2 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: No operation performed

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 3, 1944 to September 30, 1969, that I last saw the deceased alive on September 30 1969, and that death occurred at 9:13A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Eldon Call, M.D. (521)

23b. ADDRESS Rigby, Idaho

23c. DATE SIGNED Oct 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/3/69

24c. NAME OF CEMETERY OR CREMATORY Pioneer Cemetery

24d. LOCATION (City, town, or county) Rigby (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 7-1969

REGISTRAR'S SIGNATURE Anna Bredy

25. EMBALMER Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 10 1969

JUN 20 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 14 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4132
Local Reg. No. 46-69
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Star Route #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Star Route #2

3. NAME OF DECEASED (Type or Print): a. (First) FLOYD; b. (Middle) M.; c. (Last) HOSTETTER

4. DATE OF DEATH (Month) (Day) (Year): August 31, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 7, 1901

9. AGE (In years last birthday): 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Pipefitter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 464-03-8502

17. INFORMANT'S OWN SIGNATURE: Official Records — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Generalized Cardiac Hypertrophy

DUE TO (c): Healed Old Myocardial Infarcts

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Abrasions of righthand, wrist & knee
Recent subcutaneous hemorrhage of right chest wall

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Undetermined

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* INVESTIGATION *to* ONLY, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. M. Callahan 583 — (Degree or title): Coroner

23b. ADDRESS: Bonners Ferry, Idaho

23c. DATE SIGNED: 9/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 9/8/69

24c. NAME OF CEMETERY OR CREMATORY: Davis Funeral Home

24d. LOCATION (City, town, or county) (State): Clarksburg, West Virginia

DATE REC'D BY LOCAL REG.: Oct. 10, 1969

REGISTRAR'S SIGNATURE: Virgila Stone

25. EMBALMER: [signature]

LICENSE NO.: E-153

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

OCT 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 8 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4133
Local Reg. No. 44-69
Reg. Dist. No. 100

BIRTH NO.

SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (In this place): 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)
a. (First): AUGUST
b. (Middle): WILLIAM EDWARD
c. (Last): SCHLENER

4. DATE OF DEATH (Month) (Day) (Year): September 8, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 2, 1886
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Leather Merchant 22
10b. KIND OF BUSINESS OR INDUSTRY: Retail Sales
11. BIRTHPLACE (State or foreign country): Minneapolis, Minnesota
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Adolph Schlener — BIRTHPLACE: St. Anthony, Minn.
14. MOTHER'S MAIDEN NAME: Mary Schwarm — BIRTHPLACE: St. Anthony, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-03-3752 A
17. INFORMANT'S OWN SIGNATURE: Rena R. Schlener — ADDRESS: Bonners Ferry, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): ASHD — unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Bronchopneumonia — 10 days

19a. DATE OF OPERATION: no
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): no
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: no
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1, 1969, *to* 9/8, 1969, *that I last saw the deceased alive on* 9/8, 1969, *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: F. Gwam 103 — (Degree or title): MD
23b. ADDRESS: Bonners Ferry
23c. DATE SIGNED: 9/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/11/69
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry, Idaho

DATE REC'D BY LOCAL REG.: Sept. 18, 1969
REGISTRAR'S SIGNATURE: Twyla Stone
25. EMBALMER: Charles A. Malme
LICENSE NO.: E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4134
Local Reg. No. 43-69
Reg. Dist. No. 100

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
LENGTH OF STAY (In this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILLIAM	HENRY	JEFFRIES	September 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 18, 1896	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Parksville, Missouri
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John H. Jeffries — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Myrtle Jantz — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 518-24-0216
17. INFORMANT'S OWN SIGNATURE: Joy Marcy — ADDRESS: Bonners Ferry, Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Coronary Atherosclerosis, Emphysema

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1964, *to* 9/9, 1969, *that I last saw the deceased alive on* 9/8, 1969, *and that death occurred at* 2:15 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Bonners Ferry Idaho
23c. DATE SIGNED: 9/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/12/69
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: Sept. 12, 1969
REGISTRAR'S SIGNATURE: Wayla Stone
25. EMBALMER: [signature]
LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4135
Local Reg. No. 45-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED OCT 13 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY IN (this place): 25 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Al's Trailer Court

3. NAME OF DECEASED (Type or Print)
a. (First): MINNIE
b. (Middle): ALICE
c. (Last): FULGHAM

4. DATE OF DEATH (Month) (Day) (Year): September 30, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Jan. 31, 1907

9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Oakley, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: George Cox
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Eva A. Craner
BIRTHPLACE: Oakley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 518-52-7037

17. INFORMANT'S OWN SIGNATURE: Mrs. Robert K. Norwood
ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Edema

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Carcinomatosis

DUE TO (c): Carcinoma Pancreas

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 69, *to* 9/30, 1969, *that I last saw the deceased alive on* 9/30, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 153
(Degree or title): MD
23b. ADDRESS: Bonners Ferry Idaho
23c. DATE SIGNED: 10/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/4/69
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: Oct. 9, 1969
REGISTRAR'S SIGNATURE: Twyla Stone
25. EMBALMER: [signature]
LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
SEP 15 1969
BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 4136
Local Reg. No. 2
Reg. Dist. No. 670

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. Bureau of Vital Statistics Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Howe
c. LENGTH OF STAY (in this place) 2 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 19 Miles N. of Howe 670

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Butte 120
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Howe
d. STREET ADDRESS (If rural, give location) 19 Miles N. Howe

3. NAME OF DECEASED (Type or Print) a. (First) LANE b. (Middle) c. (Last) WARNER

4. DATE OF DEATH (Month) (Day) (Year) September 6, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Jan. 18, 1931

9. AGE (In years last birthday) 38
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Ranching

11. BIRTHPLACE (State or foreign country) Heyburn, Idaho

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Wallace Deloso Warner BIRTHPLACE Anamony, Ut.

14. MOTHER'S MAIDEN NAME Olive Victoria Christensen BIRTHPLACE Arizona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean 6.

16. SOCIAL SECURITY NO. 519-28-5330

17. INFORMANT'S OWN SIGNATURE Mary A. Warner ADDRESS Howe, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 9299X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suffocation — INTERVAL BETWEEN ONSET AND DEATH: 20 mins

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Crushed chest
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm 28

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Rural-Howe 120 Butte Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-6-69 3:00p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Car slipped off jack and fell

22. *I hereby certify that I attended the deceased from* As Coroner only-Did not see alive, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 3:00pm., *from the causes and on the date stated above.*

23a. SIGNATURE C. S. Marvel 683 4 (Degree or title) Butte Co. Coroner

23b. ADDRESS Arco, Idaho

23c. DATE SIGNED 9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-10-69

24c. NAME OF CEMETERY OR CREMATORY Heyburn Riverside

24d. LOCATION (City, town, or county) (State) Heyburn, Idaho

DATE REC'D BY LOCAL REG. 9-12-1969

REGISTRAR'S SIGNATURE Betty J. Marvel

25. EMBALMER C. S. Marvel

LICENSE NO. E-457

FIRM NAME Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 29 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 10 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4137
Local Reg. No. 3
Reg. Dist. No. 670

BIRTH NO.

RECEIVED

STATE OF IDAHO

SEP 15 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Moore
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 miles West of Moore

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Butte 120
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moore
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MICHAEL	DEAN	SHAFFER	September 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	July 10, 1954	15				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Salmon, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Gene Shaffer — BIRTHPLACE: Butte, Montana
14. MOTHER'S MAIDEN NAME: Gwendolyn Palmer — BIRTHPLACE: Salmon, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-68-7708
17. INFORMANT'S OWN SIGNATURE: x Gene A. Shaffer — ADDRESS: Moore, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9229

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental Gunshot wound in left upper arm and chest — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Field 31	Rural-Moore, 120 Butte, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
9-7-69 7:00p.m.		Hunting accident

22. *I hereby certify that I attended the deceased from* Attended as Coroner only, Did Not See Alive, 19__, to __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 7:00p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. D. Marvel 583 4 Butte Co. Coroner	Arco, Idaho	9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-10-69	Mt. McCaleb	Mackay, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-12-1969	Betty J. Marvel	C. D. Marvel	E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4138
Local Reg. No.
Reg. Dist. No.

Certificate of Death

RECEIVED
OCT 1 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Butte 120
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
d. STREET ADDRESS (If rural, give location): East Era Street

3. NAME OF DECEASED (Type or Print)
a. (First): GLENDLE
b. (Middle): VICTOR
c. (Last): ALLEN

4. DATE OF DEATH (Month) (Day) (Year): September 26, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 18, 1901
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Brooklyn, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S. A.

13. FATHER'S NAME: Luther Allen — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Laura Connelly — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 496-03-9952
17. INFORMANT'S OWN SIGNATURE: X Beulah M. Allen — ADDRESS: Arco, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1561

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Intra abdominal Carcinoma — ? 1 yr
DUE TO (c) Involving liver + Bile ducts

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-25, 1969, *to* 9-26, 1969, *that I last saw the deceased alive on* 9-26, 1969, *and that death occurred at* 4:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE 031 [signature] (Degree or title)
23b. ADDRESS: Arco
23c. DATE SIGNED: 9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-29-69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Arco, Idaho

DATE REC'D BY LOCAL REG.: Sept. 30, 1969
REGISTRAR'S SIGNATURE: Betty J. Marvel
25. EMBALMER: [signature]
LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 27 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4139
Local Reg. No. 496
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Oregon 38
b. COUNTY Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Vale
d. STREET ADDRESS (If rural, give location) 777 D. St. West

3. NAME OF DECEASED (Type or Print) a. (First) Helen b. (Middle) Margaret c. (Last) Glenn

4. DATE OF DEATH (Month) (Day) (Year) August 26, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept. 13, 1900

9. AGE (In years last birthday) 68
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Emmetsberg, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME C. C. Mueller
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Ophelia Bostwick
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Carl Glenn
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Poss. embolic pulmonary

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

450X

19a. DATE OF OPERATION 8-15-69

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-14 *1969, to* 8-26, *1969, that I last saw the deceased alive on* 8-26, *1969 and that death occurred at* 8.35 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS 206 E. Elm-Caldwell, Idaho

23c. DATE SIGNED 10-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/30/69

24c. NAME OF CEMETERY OR CREMATORY Valley View

24d. LOCATION (City, town, or county) Vale, (State) Oregon

DATE REC'D BY LOCAL REG. Oct. 20, 1969

REGISTRAR'S SIGNATURE Mrs Martin Walmsley

25. EMBALMER Glenn Blatchley

LICENSE NO. 362

FIRM NAME: High Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 22 1964

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 10 1983
FEB 17 1983
SEP 07 2012

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 12 1969 Bureau of Vital Statistics

State File No. 4140
Local Reg. No. 423
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Marsing
d. STREET ADDRESS (If rural, give location) Box 141

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Everett	C.	Mitchell	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 18, 1912	57		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
OE		Laramie, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles V. Mitchell	Missouri	Lylith Call	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-12-3069	Mrs Susie N. Mitchell	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 492X acedores - due to Pulmonary — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) emphysema, bronchiectasis,
DUE TO (c) Cor pulmonale - due to

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary hypertension

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-6, 1967, *to* 9-1, 1969, *that I last saw the deceased alive on* 9-1, 1969 *and that death occurred at* 7 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
M.D.		Caldwell Idaho	9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 5, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 11, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4141
Local Reg. No. 421
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Home, 127 W. Belmont St. (22)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 127 W. Belmont St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Maye	Conner	Seamons	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Aug. 16, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
(0)		Stillwell, Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William P. Hannah	Oklahoma	Margaret Ann Kincaid	Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	560-58-3660	X Billie C. Poindexter	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Inspection & History *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche. 533 M. D. Coroner	Nampa, Idaho	9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 4, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 10, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 05 2000 APR 15 1983
AUG 26 2016 JUN 02 1995

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. APR 11 1996
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4142
Local Reg. No. 451
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital (251)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette (380)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): 216 SW Blvd.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	ARNOLD	DALLAS	OLSEN

4. DATE OF DEATH (Month) (Day) (Year): September 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct. 24, 1914	54	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (21)
10b. KIND OF BUSINESS OR INDUSTRY: Carpentry
11. BIRTHPLACE (State or foreign country): Letha, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Olsen — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Lydia Conrad — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 519-01-8927
17. INFORMANT'S OWN SIGNATURE: Viola A. Olsen — ADDRESS: New Plymouth, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Alveolar hemorrhage	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Ideopathic bone marrow hypoplasia	4 mos
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hemorrage into renal pelves	

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-17-69, 19—, *to* 9-1-69, 19—, *that I last saw the deceased alive on* 9-1-69, 19—, *and that death occurred at* 2:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Charles E. Reed M.D. (379) (Degree or title)
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Park View Cemetery
24d. LOCATION (City, town, or county) (State): New Plymouth Idaho

DATE REC'D BY LOCAL REG.: Sept. 24, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

NOV 14 2005

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4143
Local Reg. No. 438
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital (05)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon (40)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma
d. STREET ADDRESS (If rural, give location) Rt. # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	H.	Sutton	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 21, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer (07)		Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George H. Sutton	Missouri	Sumantha Paulsen	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-5887A	Hugh Sutton	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

450X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic pyelonephritis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from May 22, 1969, to Sept. 1, 1969, that I last saw the deceased alive on Sept. 1, 1969, and that death occurred at 2:15P m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
W. McCann (250) (Degree or title)	222 East Elm, Caldwell, Idaho	9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 4, 1969	Parma Cemetery	Parma, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 18, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-608

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4144
Local Reg. No. 446
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 32 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital 052

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
d. STREET ADDRESS (If rural, give location): Route 1, Box 155

3. NAME OF DECEASED (Type or Print): a. (First) Donald; b. (Middle); c. (Last) Keller

4. DATE OF DEATH (Month) (Day) (Year): September 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	2-7-32	37				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Caldwell, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob H. Keller — BIRTHPLACE: Lititz, Pennsylvania
14. MOTHER'S MAIDEN NAME: Florence Seaber — BIRTHPLACE: Cleveland, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Wilma Keyser — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral infarction	1 week
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Bilateral Bronchopneumonia Pulmonary emboli	

4339

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-27, 1969, *to* 9-2-69, 19____, *that I last saw the deceased alive on* 9-2, 1969, *and that death occurred at* 1:50 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. D. Thueson, M.D.	Nampa, Idaho	9-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-5-69	Star Cemetery	Star, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22, 1969	Mrs. Martina Walmsley	M. A. Shepherd	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 16 1969 Bureau of Vital Statistics

State File No. 4145
Local Reg. No. 431
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 141 Canyon	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF [illegible] (in this place) days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Star
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 051	d. STREET ADDRESS (If rural, give location) Rt. # 1,

3. NAME OF DECEASED (Type or Print) a. (First) AGNES	b. (Middle) MARY	c. (Last) MILLER	4. DATE OF DEATH (Month) (Day) (Year) Sept. 2, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 20, 1891	9. AGE (In years last birthday) 77 — IF UNDER 1 YR. Months 11 Days 12 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Phillips Co., Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ridgley	BIRTHPLACE Indiana	14. MOTHER'S MAIDEN NAME Myrtle Hoyt	BIRTHPLACE Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-40-2783A	17. INFORMANT'S OWN SIGNATURE X William H. Miller	ADDRESS Towanda, Kansas	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute anterior myocardial infarction	hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus. ~~[illegible]~~ Gangrene of toes	

19a. DATE OF OPERATION 9-1-69	19b. MAJOR FINDINGS OF OPERATION Arteriosclerosis of femoral & iliac arteries	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 26, 1969, *to* September 2, 1969, *that I last saw the deceased alive on* September 2, 1969, *and that death occurred at* 6:05 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Charles E. Reed M.D. 376. (Degree or title)	23b. ADDRESS 222 East Elm, Caldwell, Idaho	23c. DATE SIGNED 9-9-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/5/69	24c. NAME OF CEMETERY OR CREMATORY Star Cemetery	24d. LOCATION (City, town, or county) (State) Star, Ada, Idaho
DATE REC'D BY LOCAL REG. Sept. 15, 1969	REGISTRAR'S SIGNATURE Mrs. Martin Walmsley	25. EMBALMER Larry J. Krouse	LICENSE NO. E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 6 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4146
Local Reg. No. 427
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 16 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN Caldwell
c. LENGTH OF STAY (in this place) 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Blakley Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 141
c. CITY OR TOWN Caldwell
d. STREET ADDRESS (If rural, give location) Cleveland Blvd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Emma	Edna	VanSlyke	Sept. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Oct. 4, 1879	89	10	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Self	Glasco, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel P. Fuller	Unknown	Ella Eddington	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-0805A	X C. M. VanSlyke	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* November 2, 19 66, *to* ~~September~~, 19 69, *that I last saw the deceased alive on* Sept. 2, 19 69, *and that death occurred at* 7:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Reed M.D. 379	222 East Elm, Caldwell, Idaho	9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-5-1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 15, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Charel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 15 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 18 1969 Bureau of Vital Statistics

State File No. 4147
Local Reg. No. 436
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 19 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 307 Mapel

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 307 Mapel

3. NAME OF DECEASED (Type or Print): a. (First) Herbert b. (Middle) H. c. (Last) McBee

4. DATE OF DEATH: (Month) Sept. (Day) 4, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 15, 1899

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Locksmith

10b. KIND OF BUSINESS OR INDUSTRY: Key Making

11. BIRTHPLACE (State or foreign country): Commanche, Texas

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Newton McBee
BIRTHPLACE: Texas

14. MOTHER'S MAIDEN NAME: Eunice Bullock
BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 453 46 1721 A

17. INFORMANT'S OWN SIGNATURE: X Blanche S. McBee
ADDRESS: Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4123 Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mild Diabetes & Arthritis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 Aug 1969 *to* 4 Sept, 1969, *that I last saw the deceased alive on* 4 Sept, 1969, *and that death occurred at* 930 a/p m., *from the causes and on the date stated above.*

23a. SIGNATURE: X Marquis MD (Degree or title)

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 15 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 8, 1969

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Sept. 17, 1969

REGISTRAR'S SIGNATURE: Mrs. Maitra Walmsley

25. EMBALMER: M. B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 09 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 12 1969 Bureau of Vital Statistics

State File No. 4148
Local Reg. No. 425
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa c. LENGTH OF STAY (In this place): 38 yrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 803 So. Powerline Road 000	d. STREET ADDRESS (If rural, give location): 803 So. Powerline Road

3. NAME OF DECEASED (Type or Print) a. (First): EARL	b. (Middle): W.	c. (Last): SPANGLER	4. DATE OF DEATH (Month) (Day) (Year): Sept. 4, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Aug. 29, 1894	9. AGE (In years last birthday): 75 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Operator 26	10b. KIND OF BUSINESS OR INDUSTRY: Business	11. BIRTHPLACE (State or foreign country): Jetmore, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: No Record	BIRTHPLACE: No Record	14. MOTHER'S MAIDEN NAME: No Record	BIRTHPLACE: No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. # 1 3	16. SOCIAL SECURITY NO.: 518-16-7025A	17. INFORMANT'S OWN SIGNATURE: x Marie Spangler	ADDRESS: Nampa	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Myocardial Infarction	20 min
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary artery occlusion	20 min
DUE TO (c)	Generalized + coronary art sclerosis	20 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hyperurecocemia - Gout.	20 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Nampa Canyon Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* July, 1967, *to* 4 Sept, 1969, *that I last saw the deceased alive on* 4 Sept, 1969, *and that death occurred at* 9 17 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 443	(Degree or title): M.D.	23b. ADDRESS: Nampa Idaho	23c. DATE SIGNED: 8 Sept 1969
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9/8/69	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho
DATE REC'D BY LOCAL REG.: Sept. 11, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: Richard W. Mosenbrink	LICENSE NO.: E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 12 1969

SEP 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 25 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB - 5 1986

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics
SEP 12 1969

State File No. 4149
Local Reg. No. 424
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon (42)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 20 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital (050)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada (010)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kuna
d. STREET ADDRESS (If rural, give location) Box 186

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Irene	V.	Jans	9 - 5 - 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	married	8-15-1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife (01)	same	Clayton, Minnesota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Mattison	Norway	Randy Nelson	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		X Cindy Jans	Kuna

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1538 Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 9 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-25-69, to 9-5-69, that I last saw the deceased alive on 9-5-69, and that death occurred at 11 a.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvin E. Hough	MD	Nampa Idaho	9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9-9-69	Lane Memorial Gardens	Eugene, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 11, 1969	Mrs. Martin Walmsley	Jack H. Green	E-528

FIRM NAME: Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4150
Local Reg. No. 419
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 SEP 1 1 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blvd. Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 140.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Route #2 - Box 278

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDITH	V.	POWELL	Sept. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 11, 1884	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own home	Pennsylvania	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edwin Van Winkle	No Record	Fanny Hoyt	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - - - - - -	519-58-9641	X Raymond E. Powell	Richland Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

194X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Metastatic Carcinoma
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Carcinoma Breast
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April 25, 1955, *to* Sept 5, 1969, *that I last saw the deceased alive on* Sept 4, 1969, *and that death occurred at* 3:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche M. D.	Nampa Idaho	9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/8/69	Cloverdale Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 10, 1969	Mrs. Martina Walmsley	Marvin R. Hibbila	515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 18 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4151
Local Reg. No. 435
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 9 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkview Manor 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Park View Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Fred	E.	Roberts	Sept. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 12, 1885	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Labor of	Farming	Springview, Nebraska	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Adin Roberts	Ind.	Sarah J. Hodge	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519 20 2741A	X Mary E. Roberts	Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Arteriosclerotic Heart Disease	10 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)	Cerebro-Vascular Insufficiency	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic Hypertrophic Arthritis	

4123

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1969, *to* 5 Sept, 1969, *that I last saw the deceased alive on* 5 Sept 1969, *and that death occurred at* 11:34 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Nampa, Idaho	15 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-9-1969	Craigmont I.O.O.F. Cem.	Craigmont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 17, 1969	Mrs. Martina Walmsley	[signature]	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 1 8 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 5 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4152
Local Reg. No. 430
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 16 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 3 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Apt. at Rodeo Grounds 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Box 981

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Herman c. (Last) Turner

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 2, 1892

9. AGE (In years last birthday): 76
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker 06

10b. KIND OF BUSINESS OR INDUSTRY: Rodeo Grounds

11. BIRTHPLACE (State or foreign country): Sand Springs, Arkansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James W. Turner
BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Mattie
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 516 07 7044

17. INFORMANT'S OWN SIGNATURE: X Helen M. Turner
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Gunshot Wound Head, Self Inflicted 955X

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒ XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 2 Suicide

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): At his home 31

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Nampa 142 Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 5 1969 10.00 P.M.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Used a 22 revolver

22. *I hereby certify that I attended the deceased from* Inspection Only *19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesche. 583 4 (Degree or title): M. D. Coroner

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 9-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 8, 1969

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1969

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: H. B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 16 1969
JAN 11 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 18 1969 Bureau of Vital Statistics

State File No. 4153
Local Reg. No. 434
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (In this place) D.O.A
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa 83651
d. STREET ADDRESS (If rural, give location) 1821 4th street North

3. NAME OF DECEASED (Type or Print) a. (First) NADINE b. (Middle) c. (Last) COX
4. DATE OF DEATH (Month) (Day) (Year) Sept. 6, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 17, 1924
9. AGE (In years last birthday) 45
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Arkansas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Elmer L. Marsh
BIRTHPLACE Nebraska
14. MOTHER'S MAIDEN NAME Josphine Donovan
BIRTHPLACE Nebraska
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 505-24-1992
17. INFORMANT'S OWN SIGNATURE X Wilson L Carl ADDRESS Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

887X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Peritonitis from Ruptured Bowel
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ~~XXXXXX~~ Bilateral Hemorrhage into Lungs
DUE TO (c) This all due to Trauma. Cause of this not definitely proven yet but believed due to a fall on a fishing trip 2 days or so before her death.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Inspection & Autopsy, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 6.00P m., from the causes and on the date stated above.

23a. SIGNATURE John C Wesch 583 + (Degree or title) M. D. Coroner
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 9-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Sept. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY Alliance Cemetery
24d. LOCATION (City, town, or county) (State) Alliance, Nebraska

DATE REC'D BY LOCAL REG. Sept. 17, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER M. B. Shepherd
LICENSE NO. 497
FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4154
Local Reg. No. 443
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142 SEP 2 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (In this place) months
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Blvd. Nursing Home 284

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idah o b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 472 Nampa Caldwell Blvd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LEONE		HALL	9	7	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
F.	White	never married	Nov, 17, 1895	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home maker	Home	Everton, Missouri	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clem L. Hall	Illinois	Mary Kelley	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		No	x Mrs Morris Fullerton	Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

3471

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Thrue Cerebral Atrophy — INTERVAL BETWEEN ONSET AND DEATH 9 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December, 1962 to Sept, 1969, *that I last saw the deceased alive on* 9 Sept, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Raymond Olsen MD 115	Nampa Ida	17 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/12/69	Meridian Cemetery	Meridian Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22, 1969	Mrs. Martina Walmsley		E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4155
Local Reg. No. 432
Reg. Dist. No. 360

BIRTH NO.

SEP 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa	c. LENGTH OF STAY (In this place): Weeks 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050	d. STREET ADDRESS (If rural, give location): 415 Diamond St.

3. NAME OF DECEASED (Type or Print)	a. (First) VADA	b. (Middle) MARIE (Tiser)	c. (Last) McCONNELL	4. DATE OF DEATH (Month) 9 (Day) 7 (Year) 69
5. SEX: F	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced	8. DATE OF BIRTH: April 30, 1936	9. AGE (In years last birthday): 33 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: home	11. BIRTHPLACE (State or foreign country): Caldwell, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: George E. Skelton	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Viola Hoots Bittick	BIRTHPLACE: Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-38-2245	17. INFORMANT'S OWN SIGNATURE: + Viola Hoots	ADDRESS: Wilder, Idaho	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

584X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): pulmonary edema

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): L. Heart failure

DUE TO (c): glomerulo sclerosis

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

multiple sclerosis +

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1954, *to* 9/7, 1969, *that I last saw the deceased alive on* 9 Mar 69, 19____, *and that death occurred at* 3P *m., from the causes and on the date stated above.*

23a. SIGNATURE: B. Marcusen 326 (Degree or title) MD	23b. ADDRESS: Nampa Idaho	23c. DATE SIGNED: 9/11/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9/12/69	24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery	24d. LOCATION (City, town, or county): Nampa Canyon (State): Idaho
DATE REC'D BY LOCAL REG.: Sept. 15, 1969	REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley	25. EMBALMER: Don W. Sinclair	LICENSE NO.: F-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4156
Local Reg. No. 437
Reg. Dist. No. 360

RECEIVED
Bureau of Vital Statistics
SEP 18 1969

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Park View Manor
d. STREET ADDRESS (If rural, give location): Lincoln Park

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Onie	I.	Stine	September 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Oct. 25, 1880	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Retired	Oregon City, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John B. David	Unknown	Juliette David	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Mrs C. W. Maxwell	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Decompensation & Renal Failure
DUE TO (c) Age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3 Sept., 1969, *to* 8 Sept., 1969, *that I last saw the deceased alive on* 8 Sept., 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. K. Mangum MD	Nampa Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-11-1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 18, 1969	Mrs. Martina Walmsley	Susy M. Flahiff	E-393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED OCT 1 1969 Bureau of Vital Statistics

State File No. 4157
Local Reg. No. 465
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (In this place):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Owyhee (37)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): Rt. # 1

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital (05)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Theodore	John	Allison	Sept. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 4, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (04)		Parma, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Jefferson Allison	Ohio	Cora Shupe	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-12-2248	Estella B. Allison	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1621 Cancer lung — INTERVAL BETWEEN ONSET AND DEATH: June 1969-4mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1962 *to* Sept 9, 1969, *that I last saw the deceased alive on* Sept 8, 1969, *and that death occurred at* 4:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hal E. Reynolds (437) MD	Caldwell, Idaho	9-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 12, 1969	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 30, 1969	Mrs. Martina Walmsley		E-285

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 23 1969 Bureau of Vital Statistics

State File No. 4158
Local Reg. No. 448
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Canyon (41) b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell LENGTH OF STAY (In this place): d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 140 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell d. STREET ADDRESS (If rural, give location): Rt. # 6

3. NAME OF DECEASED (Type or Print): a. (First) Carl	b. (Middle) R.	c. (Last) Hoffman	4. DATE OF DEATH (Month) (Day) (Year): Sept. 9, 1969			
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: July 16, 1899	9. AGE (In years last birthday): 70	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OD	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Canon City, Colorado		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Gus Hoffman	BIRTHPLACE: Missouri		14. MOTHER'S MAIDEN NAME: Paulena Brunswick		BIRTHPLACE: Wisconsin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: No		17. INFORMANT'S OWN SIGNATURE: B E Hoffman		ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) *This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 450X Pulmonary Embolism	INTERVAL BETWEEN ONSET AND DEATH: Normal
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b):	
	DUE TO (c):	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Cystic Fibrosis - Lungs	Years
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?		

22. *I hereby certify that I attended the deceased from* Aug 14, 19 69, *to* Sept 9, 19 69, *that I last saw the deceased alive on* Sept 8, 19 69, *and that death occurred at* 4:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD	23b. ADDRESS: Caldwell Ida	23c. DATE SIGNED: 9-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 12, 1969	24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery	24d. LOCATION (City, town, or county): Nampa, Idaho	(State)
DATE REC'D BY LOCAL REG.: Sept. 22, 1969	REGISTRAR'S SIGNATURE: Mrs Martina Walmsley	25. EMBALMER: Kenneth E Pence		LICENSE NO.: E-395
		FIRM NAME: Dakan Chapel, Caldwell, Idaho		

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 16 1969 Bureau of Vital Statistics

State File No. 4159
Local Reg. No. 429
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 436 Midland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edythe	H.	Jones	Sept. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 5, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home-Maker	At Home	Ayr, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Brown	Ohio	Allie Jeffries	Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 18 3357	X Lyle Jones	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral A-S
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2/8/1961, to 9/9/1969, that I last saw the deceased alive on 9/9/1969, and that death occurred at 5:45P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
454 Dalton MD	Nampa, Idaho	9/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-12-69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 15, 1969	Mrs. Martina Walmsley	M. B. Shepherd	473

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 2 9 1969

OCT 7 1985

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 18 1969 Bureau of Vital Statistics

State File No. 4160
Local Reg. No. 439
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1421 Dearborn

3. NAME OF DECEASED (Type or Print)
a. (First) Bessie
b. (Middle) Fay
c. (Last) Myers

4. DATE OF DEATH (Month) (Day) (Year) Sept. 11, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Sept. 17, 1884
9. AGE (In years last birthday) 84
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hurley, South Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Oscar O. Snyder
BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME May Amelia Deno
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-36-1083B
17. INFORMANT'S OWN SIGNATURE [signature]
ADDRESS

18. CAUSE OF DEATH 1719
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Leio myosarcoma with metastases — INTERVAL BETWEEN ONSET AND DEATH: uncertain

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Post operative 5 hours for resection of large intra abdominal metastatic lesions — 5 hours

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION as noted above
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1953, *to* 9-11, 1969, *that I last saw the deceased alive on* 9-11, 1969, *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Charles E Kerrick 280 (Degree or title) MD
23b. ADDRESS 1819 Ellis Caldwell Idaho
23c. DATE SIGNED 9-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Sept. 18, 1969
REGISTRAR'S SIGNATURE Mrs Martina Walmsley
25. EMBALMER Kenneth E. Spence
LICENSE NO. E-395

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4161
Local Reg. No. 469
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY NI Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place) 6 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 343 05

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 211 Ivywild

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
BETTY	JO	CHARLTON	9	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	4/18/1926	43		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cambridge, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Jackson — BIRTHPLACE Boise, Idaho
14. MOTHER'S MAIDEN NAME Elsie Pearl Rhoades, — BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE + Melvin Charlton — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

7340
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Scleroderma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 11, 1966, *to* September 13, 19 69, *that I last saw the deceased alive on* September 13, 19 69, *and that death occurred at* 11:45a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Reed 379 N.	M.D.	222 East Elm, Caldwell, Idaho	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	9-16-69	Cloverdale Cemetery	Boise Ada	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 2, 1969	Mrs. Martina Walmsley	Elbert T. Pearson	E-512

FIRM NAME: Relyea Mortuary RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED IDAHO

Bureau of Vital Statistics

State File No. 4162
Local Reg. No. 440
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon — SEP 1 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY IN [illegible]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho — b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 723-12th Avenue Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	D.	Parsons	September 13, 1969.

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 25, 1878	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Contractor 11.	Building	Chatsworth, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Ross Parsons	Ohio	Anna F. Dewees	No Record.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-1709	M. D. Parsons	Nampa, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO ~~DUE TO~~ (b) Acute Diaphragmatic Myocardial Infarction
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 12, 1962, to Sept 13, 1969, that I last saw the deceased alive on Sept 12, 1969, and that death occurred at 12:45A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wesche 56° MD	Nampa Idaho	9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 16, 1969	Hillcrest Mem. Gardens	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 18, 1969	Mrs. Martina Walmsley	Richard W. Messenbrink	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 23 1969 Bureau of Vital Statistics

State File No. 4163
Local Reg. No. 445
Reg. Dist. No. 360
BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 6 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 715 7th Ave. So.

3. NAME OF DECEASED (Type or Print) a. (First) Rudolph b. (Middle) J. c. (Last) Salek
4. DATE OF DEATH (Month) (Day) (Year) Sept. 13, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH April 15, 1887
9. AGE (In years last birthday) 82 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer 22
10b. KIND OF BUSINESS OR INDUSTRY Retail Store
11. BIRTHPLACE (State or foreign country) Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Salek BIRTHPLACE Czechoslovakia
14. MOTHER'S MAIDEN NAME Elenora Suskova BIRTHPLACE Czechoslovakia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 54 6403
17. INFORMANT'S OWN SIGNATURE X John G Salek ADDRESS Nampa, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
4109
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Shock & Pulmonary Edema
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac Insufficiency
DUE TO (c) Coronary Occlusion
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/22/ , 19 69 to 9/13/ , 19 69 , that I last saw the deceased alive on 9/13/ , 19 69, and that death occurred at 1.40A m., from the causes and on the date stated above.

23a. SIGNATURE +54 John Salek (Degree or title) MD
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 9/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-17-69
24c. NAME OF CEMETERY OR CREMATORY Mount Calvary
24d. LOCATION (City, town, or county) Nampa, Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 22, 1969
REGISTRAR'S SIGNATURE Mrs. Martin Walmsley
25. EMBALMER Glen G. Sirum
LICENSE NO. 498
FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 3 1969 Bureau of Vital Statistics

State File No. 4164
Local Reg. No. 471
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1124 12th Ave. So.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Estelle	A.	Nefzger	Sept. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Nov. 20, 1905	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	At Home	Emmett, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Marrs	Nebraska	Ella Brower	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 12 9020	X Merlin J. Nefzger	Nampa, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial rupture — INTERVAL BETWEEN ONSET AND DEATH: seconds

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) acute myocardial injuction — 24 hrs
DUE TO (c) coronary atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9/24/ , 19 63 to 9/14/ , 19 69 , that I last saw the deceased alive on 9/14/ , 19 69 and that death occurred 6:40A m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]		Nampa, Idaho	9/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-17-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 2. 1969	Mrs. Martina Walmsley	W. B. Shepherd	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38:206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 1 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4165
Local Reg. No. 449
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH (40)
a. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rt. # 2, Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Home of John Gobel OOR

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (41)
a. STATE Idaho
b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 2112 Blaine St.

3. NAME OF DECEASED (Type or Print) a. (First) Lelia b. (Middle) Jane c. (Last) Roberson
4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Oct. 26, 1883
9. AGE (In years last birthday) 85 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OO
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) English, Indiana
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME B. C. Roberson BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Emeline Gregory BIRTHPLACE Indiana
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-20-6384
17. INFORMANT'S OWN SIGNATURE Bessie Hasle ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

442X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Embolism xxx Aneurysm — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Inspection Only, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8.00 A m., from the causes and on the date stated above.

23a. SIGNATURE Henry C. Wesche (583) (4) (Degree or title) M.D. Coroner
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 9-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. Sept. 22, 1969
REGISTRAR'S SIGNATURE Mrs. Martin Walmsley
25. EMBALMER Rodney W Dakan
LICENSE NO. E-68
FIRM NAME: Dakan Chapel, Caldwell,, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4166
Local Reg. No. 442
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
SEP 22 1969

1. PLACE OF DEATH
a. COUNTY (4) Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 301 Midland Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
d. STREET ADDRESS (If rural, give location) Route #2, Box 358

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Chrystal	Beulah	Seale	Sept.	14	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Jan. 6, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	at home	Portland, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin F. Hirsch	Oregon	Belle Spencer	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	544-20-8331	Arthur J. Seale	Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1830 Carcinoma of Ovary — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-13-67, 19__, to Sept. 14, 19 69, that I last saw the deceased alive on Sept. 13, 19 69, and that death occurred at 3 a.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvin E. Hough MD	Nampa Idaho	9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/18/69	Arlington Cemetery	Arlington, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 19, 1969	Mrs. Martin Walmsley	Richard W. Messenbrink	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4167
Local Reg. No. 447
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Homedale
b. COUNTY: Owyhee
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): Homedale Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jessie		Thomas	Sept. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Indian	Widowed	1880	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Battle Mt. Nevada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dick Crum	Unknown	Annie Coppenhagen	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
	Unknown	X Earl D. Crum

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — 4 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

4123

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I Hereby certify that I attended the deceased from Jan 1, 1960, to Sept 14, 1969, that I last saw the deceased alive on Sept 13, 1969, and that death occurred at 9 a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Caldwell Ida	9-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Sept. 14, 1969	Owyhee Nevada Cemetery	Owyhee, Nevada

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22, 1969	Mrs. Martina Walmsley	Kenneth E. Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4168
Local Reg. No. 441
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141) — SEP 2 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memori al Hospital (051)

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 223 Mead

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ruth	Ina	Crozer	Sept. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Never Married	Jan 31, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
(50)		Akron, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis Morgan Crozier	Iowa	Rosella Newby	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	540-38-6587	Mrs. Howard Toft	

18. CAUSE OF DEATH (1570)
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Liver Failure	2 weeks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Carcinomatosis	2 months
DUE TO (c)	Carcinoma of Head of Pancreas	4 months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 1, 1969, *to* 15 Sep, 1969, *that I last saw the deceased alive on* 14 Sep, 1969, *and that death occurred at* 4:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Krause (295)	M.D.	Caldwell Idaho	16 Sep 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 17, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 19, 1969	Mrs. Martina Walmsley	Kenneth E. Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 20 1969
JUN 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED OCT 7 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4169
Local Reg. No. 477
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (If in this place): 2½ Mths.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. View Nursing Home 360

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1217 Albany St.

3. NAME OF DECEASED (Type or Print)
a. (First): Mabel
b. (Middle):
c. (Last): Malaise

4. DATE OF DEATH (Month) (Day) (Year): Sept. 15, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 13, 1880
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months 9, Days 2 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Webster City, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John H. Smalley — BIRTHPLACE: New. Jersey
14. MOTHER'S MAIDEN NAME: Sophia Gray — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-26-8470A
17. INFORMANT'S OWN SIGNATURE: Lowell R Malaise — ADDRESS:

4169

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary sclerosis & thrombosis

DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 14, 1969, *to* Sept 15, 1969, *that I last saw the deceased alive on* Sept 16, 1969, *and that death occurred at* 5 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 166 MP
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 10-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-18-1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 6, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4170
Local Reg. No. 453
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 29 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 141 Canyon	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF STAY (In this place) 5 Weeks	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mountain View Terrace 360	d. STREET ADDRESS (If rural, give location) 10250 Ustick Road

3. NAME OF DECEASED (Type or Print) a. (First) FLORENCE b. (Middle) JENNIE c. (Last) MARTIN

4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
Female	White	Widowed	June 20, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Worked for Orange County, 08	Cal. Schools	St. Libora, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Franklin Samuel Pearce	Maryland	Jane Denson	Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.		564-24-2829-A	M Horn L.P.N.	Box 505 Notus

5710

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	LAENNEC'S CIRRHOSIS	3 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	HEPATIC COMA	2 weeks
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 25, 1969, *to* September 15, 1969, *that I last saw the deceased alive on* September 11, 1969, *and that death occurred at* 10:20 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
884 D. David Johnson	MD	1819 Ellis, CALDWELL, IDAHO	9/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-18-69	Dry Creek Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 26, 1969	Mrs. Martina Walmsley	Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED SEP 23 1969 Bureau of Vital Statistics

State File No. 4171
Local Reg. No. 444
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place): wks. 300
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 504 4th St. So.,

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RUTH	L.	MOORE	Sept. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Aug. 26, 1903	66	0 / 19	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	At Home	Idaho Springs, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Lalummandier	Missouri	Carrie Johnson	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-1903D	Family Records, By: Mary J. Moore	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Insulin Induced Coma — INTERVAL BETWEEN ONSET AND DEATH: 1 Bdays

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7/22/ 19 63 to 9/15/ 19 69, that I last saw the deceased alive on 9/15/ 19 69, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Rudd W. Brown MD	619 So. Canyon, Nampa, Idaho	9/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/17/69	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22, 1969	Mrs. Martin Walmsley	Richard W. Messenbrink	E-484

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 4172
Local Reg. No. 450
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Canyon — SEP 24 1969
b. CITY OR TOWN: Caldwell — LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Owyhee
c. CITY OR TOWN: Homedale
d. STREET ADDRESS (If rural, give location): P. O. BOX 456

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Orville	E.	White	Sept. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 16, 1910	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.S. Army 05	Retired	Edison, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel F. White	Edison, Neb.	Eva Mae Bowen	Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWII	506-01-4852	Anna White	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebrovascular Accident — 4 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 1, 1963, *to* Sept 15, 1969, *that I last saw the deceased alive on* Sept 10, 1969, *and that death occurred at* 2:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Caldwell Ida	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 18, 1969	Marsing-Homedale Cemetery	Homedale, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 23, 1969	Mrs. Martina Walmsley	Leonard P. Flahiff	E-481

FIRM NAME: Homedale's Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4173
Local Reg. No. 459
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141 SEP 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell Bureau of Vital Statistics
c. LENGTH OF (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 207 South State

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) Howard
c. (Last) Mercer

4. DATE OF DEATH (Month) (Day) (Year) September 17, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 20, 1907
9. AGE (In years last birthday) 62 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer 22
10b. KIND OF BUSINESS OR INDUSTRY Grocery
11. BIRTHPLACE (State or foreign country) Langson, North Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William John Mercer BIRTHPLACE Bathgate, No. Dak.
14. MOTHER'S MAIDEN NAME Martha Keown BIRTHPLACE -Morden, Manitoba, Canada.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-6766
17. INFORMANT'S OWN SIGNATURE Mrs. Gazelle Mercer ADDRESS Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Squamous cell carcinoma of the lung with metastases

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Essential hypertension

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/17, 1964, to 9/17, 1969, that I last saw the deceased alive on 9/17, 1969, and that death occurred at 12noon m., from the causes and on the date stated above.

23a. SIGNATURE Gerald C. Bauman 034 (Degree or title) M.D.
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 9/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 20 1969
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 29, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 0 1969
MAY 1 7 2016

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4174
Local Reg. No. 456
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY (141) Canyon — SEP 30 1969 — Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell — STATION OF STAY (in this place) 3 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hsop. (057)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho — b. COUNTY Canyon (140)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Parma

d. STREET ADDRESS (If rural, give location) Route # 5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Virginia		Orta	Sept. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Sept. 5, 1916	53	0	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Self	Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Unknown	X Tillara	Orta

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	50% third degree fire burns	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	house fire	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

E90X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident (1)	home (01)	Notus, Canyon (140) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
9 - 14-69 9p.m.		house fire

22. *I hereby certify that I attended the deceased from* 9-14-69, 19___, *to* 9-17-69, 19___, *that I last saw the deceased alive on* 9-17-69, 19___, *and that death occurred at* 1:45a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. M. Fahrang, M.D. (425 md)	227 E. Logan, Caldwell, Idaho	9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-19-1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4175
Local Reg. No. 457
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon — SEP 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 420 15th Avenue South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Essa	K.	Woodford	September 17, 1969.

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	September 4, 1876	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Marshalltown, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Oscar Kallenberg	Sweden	Nancy Jane O'Neal	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-22-1486	Mrs Gladys Splinter	Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nasal hemorrhage
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-8, 1969, *to* 9-17, 1969, *that I last saw the deceased alive on* 9-16, 1969, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvin E Blough MD	Nampa Idaho	9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 19, 1969	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29, 1969	Mrs Martina Walmsley	Richard W. Meservey	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4176
Local Reg. No. 466
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 1 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 2001 Cleveland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lucille	P.	Brumfield	Sept. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Feb. 10, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Haines, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Cryderman	Canada	Bertha Toney	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-26-9194A	Patricia A. Kremer	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1621 Ca of lung

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: unknown 1 yr?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 19, 1969, *to* September 18, 1969, *that I last saw the deceased alive on* September 18, 1969, *and that death occurred at* 9:53a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Muller 250	M. D.	222 East Elm, Caldwell, Idaho	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 20, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 30, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4177
Local Reg. No. 468
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon (41) OCT 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Marsing
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Ealan b. (Middle) A. c. (Last) Ramsey

4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 5, 1885

9. AGE (In years last birthday) 83
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OD

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) McLeansboro, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Ramsey
BIRTHPLACE Tennessee

14. MOTHER'S MAIDEN NAME Catherine Unknown
BIRTHPLACE Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-22-7730A

17. INFORMANT'S OWN SIGNATURE Mary Lou Wilson
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

8199

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute Myocardial Infarction - Muscle failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis — Progressive
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Auto Accident - Right Hemopneumothorax; Fractured Right Humerus; Acute Intra-abdominal bleeding — 2 hrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Auto accident - Highway - one car

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) Wilder (COUNTY) Canyon (140) (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 18 Sep 1969 - 8:00 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 Sep, 1969, to 18 Sep, 1969, that I last saw the deceased alive on 18 Sep, 1969, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE Charles E. Krause (295) M.D. (Degree or title)

23b. ADDRESS Caldwell, Idaho

23c. DATE SIGNED 27 Sep 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 22, 1969

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Oct. 1, 1969

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Robert W. Dakan

LICENSE NO. E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4178
Local Reg. No. 470
Reg. Dist. No. 360

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 142 OCT 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY IN (this place) 2 WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 115 18th Ave. North

3. NAME OF DECEASED (Type or Print) a. (First) Eusebio b. (Middle) Chavez c. (Last) Vidales

4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1969

5. SEX Male

6. COLOR OR RACE Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Sept. 30, 1895

9. AGE (In years last birthday) 73
IF UNDER 1 YEAR Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Labor 06

10b. KIND OF BUSINESS OR INDUSTRY Landscape Gardener

11. BIRTHPLACE (State or foreign country) Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Salvadore Vidales
BIRTHPLACE Mexico

14. MOTHER'S MAIDEN NAME Cipriana Chavez
BIRTHPLACE Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 452 38 9363

17. INFORMANT'S OWN SIGNATURE X Beatrice Mendez ADDRESS Nampa

4189

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of Myocardial Infarct — Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary Occlusion — 8 days

DUE TO (c) DSA

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 7, 1969 *to* Sept 18, 1969, *that I last saw the deceased alive on* Sept 16, 1969 *and that death occurred at* 12:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Gaylen Olsen (Degree or title) MD

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED 9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-22-69

24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery

24d. LOCATION (City, town, or county) Nampa, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 2, 1969

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Allen S. Siren

LICENSE NO. 498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 16 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 30 1969

Bureau of Vital Statistics

State File No. 4179
Local Reg. No. 460
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place) CS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE 38 Oregon
b. COUNTY 555 Malheur
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arock
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Eugenio	James	Larrusea	Sept. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Sept. 17, 1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CO		Delamar, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Larrusea	Spain	Florentina Urresti	Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		X Mrs Ed Carter	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CVA, c complications

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Decubiti c infection
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9/17/69 to 9/17/69, that I last saw the deceased alive on 9/17/69, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald C Bauman 034 M.D.	Caldwell Ida	9/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 23, 1969	Jordan Valley Cemetery	Jordan Valley, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29, 1969	Mrs Martina Walmsley	Rodney C. Dakan	E-638

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4180
Local Reg. No. 461
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY (41) Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital (051)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho (13)
b. COUNTY Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 321 Aven St.

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) L. c. (Last) Wise

4. DATE OF DEATH (Month) (Day) (Year) Sept. 19, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH Feb. 9, 1908

9. AGE (In years last birthday) 61
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OO

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cordell, Oklahoma

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lewis N. Wise
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Rosilla J. Eastman
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs Lora Robertson
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 4 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 69 *to* Sept 19 69, *that I last saw the deceased alive on* Sept 19 69, *and that death occurred at* 4P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 258 (Degree or title)

23b. ADDRESS 222 East Logan

23c. DATE SIGNED 9-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 22, 1969

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Sept. 29, 1969

REGISTRAR'S SIGNATURE Mrs. Martin Walmsley

25. EMBALMER Rodney W. Dakan

LICENSE NO. E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 1 3 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 29 1969
Bureau of Vital Statistics

State File No. 4181
Local Reg. No. 454
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 140 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilder
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 Home of Sister, Mrs. Roy Sorrells

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1020 N. 29th

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Everett	R.	Dennis	Sept. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Dec. 8, 1907	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Van Zant, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Dennis	Kentucky	Anna Miller	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-20-6984
17. INFORMANT'S OWN SIGNATURE Alice M. Sorrell ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1519 Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection & History, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wenke 583 M. D. Coroner	Nampa, Idaho	9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 25, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 26, 1969	Mrs. Martina Walmsley	Rodney C. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 1969

OCT 3 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 2 7 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 4182
Local Reg. No. 458
Reg. Dist. No. 360

BIRTH NO.

SEP 3 0 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 14 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (In this place) 3 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D. O. A. -Caldwell Mem. Hosp. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 604 6th St. No. Ext.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VERNA	D. (McMahon)	TATE	Sept. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Sept. 16, 1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	At Home	Moville, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Howard F. Day	Iowa	Shara L. Igou	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	479-03-2807	x James R Tate	Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Accidental probably 2° to chest &/or head injuries

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
—	—	

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)
Accident	Highway 06	Jordan Valley 3855 Malheur Oregon

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
9	21	69	?:10 A.M.		Auto Accident

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1000 P. m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald C. Bauman 034	M.D.	Caldwell Idaho	9/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/25/69	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29, 1969	Mrs. Martina Walmsley	Jerry J. Krouch	E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4183
Local Reg. No. 452
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 29 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route #6 Nampa 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Route #6 Nampa

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
RICHARD	A.	TISER	9	21	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	Married	June 25, 1930	39		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Parts Manager 26	Automobile	Steele, N. Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard A. Tiser, Sr.	Indiana	Alice Lindblad	N. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes 1951 to 1954 c.	518-30-2492	Mrs. Burnetta Dunn Tiser	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Inspection & Autopsy, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 7:15 m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Worcke 583 4 M. D. Coroner	Nampa Idaho	9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/24/69	Kohlerlawn Cemetery	Nampa Canyon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 26, 1969	Mrs. Martina Walmsley	Joyce Simpson	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

SEP 3 0 1969
SEP 2 9 1992

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4184
Local Reg. No. 479
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 Canyon OCT 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY IN THIS PLACE 7 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 296 Park View Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2018 Ellis Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NELLIE	M.	YOUNG	Sept. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Never married	Sept. 6, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher 12	Education	Jefferson, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
E. S. Young	---	Helen A. Stearns	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	No Record	Mrs. K. E. Young LLLO Hays	Boise, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Hemorrhage Thrombosis — Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized A.S.H.D. — 12 yrs
DUE TO (c) Diabetes Mellitus — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-30, 1963, to Sept 21, 1969, that I last saw the deceased alive on September, 1969, and that death occurred at 8:00 PM, from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Grayson O. Brown 115	MD	Nampa Idaho	2 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-27-69	Kuna Cemetery	Kuna, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
October 7, 1969	Mrs. Martina Walmsley	Robert G. Rose	E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4185
Local Reg. No. 455
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140 — SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parma, Hiway # 95 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma
d. STREET ADDRESS (If rural, give location): Box 661

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Henry	Combs	Sept. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Aug. 3, 1944	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Police Officer 08		Caldwell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Shade Combs	Missouri	Laura Maggard	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes		X Linda Maxine Combs	Box 661 Parma

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

965X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Gunshot Wound of Chest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
3 Homicide	Highway 31	U.S. 20-26 near Parma Canyon Idaho 140

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Sept 22 1969 1.00 AM		Shot while investigating

22. *I hereby certify that I attended the deceased from* Inspection & Autopsy, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 1.00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Weeks 583	M. D. Coroner	Nampa, Idaho	9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 24, 1969	Marsing-Homedale Cemetery	Marsing, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 26, 1969	Mrs. Martin Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 1 1969

OCT 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 6 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 9 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

JAN 26 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

State File No. 4186
Local Reg. No. 489
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 142 Canyon	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa; c. LENGTH OF STAY (In this place) months	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor Nursing Home 301	d. STREET ADDRESS (If rural, give location) ---

3. NAME OF DECEASED (Type or Print)	a. (First) MARTHA	b. (Middle) ELLEN	c. (Last) NEWTON	4. DATE OF DEATH (Month) (Day) (Year) Sept. 22, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 27, 1883	9. AGE (In years last birthday) 86 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Grove Springs, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William D. Shaddock	BIRTHPLACE Tennessee	14. MOTHER'S MAIDEN NAME Martha Cavanaugh	BIRTHPLACE No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-26-1136	17. INFORMANT'S OWN SIGNATURE x Benford E Newton	ADDRESS Boise, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Atherosclerotic Brain thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 31, 1968, *to* 22 Sept, 1969, *that I last saw the deceased alive on* 22 Sept, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Gryden Olson (Degree or title) 115	23b. ADDRESS Nampa Idaho	23c. DATE SIGNED 10 Oct 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/24/69	24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery	24d. LOCATION (City, town, or county) (State) Caldwell, Canyon, Idaho
DATE REC'D BY LOCAL REG. Oct. 14, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Richard W. Mesenbrink	LICENSE NO. E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4187
Local Reg. No. 462
Reg. Dist. No. 360

BIRTH NO.

SEP 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell	c. LENGTH OF STAY (In this place):
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051	d. STREET ADDRESS (If rural, give location): Rt. # 3

3. NAME OF DECEASED (Type or Print)	a. (First) Don	b. (Middle) H.	c. (Last) Stevens	4. DATE OF DEATH (Month) (Day) (Year) Sept. 22, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: June 30, 1878	9. AGE (In years last birthday): 91 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Claremont, Minnesota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Fred Stevens	BIRTHPLACE: New Hampshire	14. MOTHER'S MAIDEN NAME: Viola Spalding	BIRTHPLACE: New Hampshire	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 543-32-0042	17. INFORMANT'S OWN SIGNATURE: Olive M. Troyer	ADDRESS:	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Arteriosclerosis	uncertain
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Prostatism & urinary retention requiring indwelling Catheter	6 Months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Possibility of neoplasm with liver & bone marrow involvement but not confirmed by biopsy	uncertain

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* 9-22, 1969, *that I last saw the deceased alive on* 9-21, 1969, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Charles E Kemick	28° (Degree or title): MD	23b. ADDRESS: 1819 Ellis St Caldwell Idaho	23c. DATE SIGNED: 9-24-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 24, 1969	24c. NAME OF CEMETERY OR CREMATORY: Roswell Cemetery	24d. LOCATION (City, town, or county) (State): Roswell, Idaho
DATE REC'D BY LOCAL REG.: Sept. 29, 1969	REGISTRAR'S SIGNATURE: Mrs Martina Walmsley	25. EMBALMER: Rodney W. Ador	LICENSE NO.: E-508

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 1 1971
MAR 1 9 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 2 1969 Bureau of Vital Statistics

State File No. 4188
Local Reg. No. 467
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place): days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing, Idaho
d. STREET ADDRESS (If rural, give location): Box 176

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	SENECA	WALKER	September 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 12, 1892	77	0 / 10	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher	Cattleman	Elgin, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph A. Walker	Canada	Martha Barker	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-6320	Family Records, By: Jay J. Krouse	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudde

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarction
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5/13/ , 19 67 to 9/22/ , 19 69 , that I last saw the deceased alive on 9/22/ , 19 69 and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dr. Saltzer MD	Nampa	9/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/26/69	Wilson Cemetery	Owyhee County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 1, 1969	Mrs. Martina Walmsley	Marvin R. Hilchila	515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 23 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4189
Local Reg. No. 474
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 142 OCT 6 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa Bureau of Vital Statistics c. LENGTH OF STAY (In this place): Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Melba
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050	d. STREET ADDRESS (If rural, give location): Star Route,

3. NAME OF DECEASED (Type or Print) a. (First): RALPH	b. (Middle): E.	c. (Last): BAILEY	4. DATE OF DEATH (Month) (Day) (Year): Sept. 24, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Jan. 11, 1889	9. AGE (In years last birthday): 80 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: Agricultural	11. BIRTHPLACE (State or foreign country): Carbondale, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William W. Bailey	BIRTHPLACE: Kansas	14. MOTHER'S MAIDEN NAME: Lina Luthey	BIRTHPLACE: Switzerland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-42-4241	17. INFORMANT'S OWN SIGNATURE: Lydia F. Bailey	ADDRESS: Melba, Idaho	

4412

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Rupture of abdom. aortic aneurysm.	20 Min
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Dessecting aneurysm - aorta	4-5 yrs
DUE TO (c)	atherosclerosis - generalized	30 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Nephroarteriolar sclerosis	10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1956, *to* 24 Sept, 1969, *that I last saw the deceased alive on* 24 Sept, 1969, *and that death occurred at* 5 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] +43	(Degree or title): M.D.	23b. ADDRESS: Nampa Idaho	23c. DATE SIGNED: 30 Sept 1969
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9/27/69	24c. NAME OF CEMETERY OR CREMATORY: Wilson Cemetery	24d. LOCATION (City, town, or county) (State): Owyhee County, Idaho
DATE REC'D BY LOCAL REG.: Oct. 3, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: Larry J. Krouch	LICENSE NO.: E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 1 1969 Bureau of Vital Statistics

State File No. 4190
Local Reg. No. 464
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 4 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1904 East Sherman St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1904 East Sherman St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MAGGIE	MOLSBEE	DRAKE	Sept. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Nov. 5, 1873	95		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Rogersville, Tennessee	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Abe Molsbee	Pennsylvania	Sue Looney	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-40-5120A	[signature]	Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4123 Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Arteriosclerotic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1950 19__ to Sept 24, 19 69, that I last saw the deceased alive on Sept 24, 19 69 and that death occurred at 7 A m., from the cause and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Nampa Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/26/69	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 30, 1969	Mrs. Martina Walmsley	[signature]	E-496

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 1 1969 Bureau of Vital Statistics

State File No. 4191
Local Reg. No. 463
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 142 Canyon	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa; LENGTH OF STAY (In this place) yrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 142 Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 912 - 2nd St. No., 600	d. STREET ADDRESS (If rural, give location) 912 2nd St. No.,

3. NAME OF DECEASED (Type or Print)	a. (First) RALPH	b. (Middle) MITCHELL	c. (Last) ROSS	4. DATE OF DEATH (Month) (Day) (Year)	Sept. 24, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 22, 1901	9. AGE (In years last birthday) 68	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 21	10b. KIND OF BUSINESS OR INDUSTRY U. S. Air Force	11. BIRTHPLACE (State or foreign country) Richmond, Maine	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Ross	BIRTHPLACE Canada	14. MOTHER'S MAIDEN NAME Charlotte Trenholm	BIRTHPLACE Canada		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) 22 yrs-Ret-9	16. SOCIAL SECURITY NO. 547-26-4860	17. INFORMANT'S OWN SIGNATURE X John S White	ADDRESS Nampa, Ida.	

4109 30/53 4

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coroner Occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection & History *, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 2:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Wesche 583 4	(Degree or title) M. D. Coroner	23b. ADDRESS Nampa, Idaho	23c. DATE SIGNED 9-27-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/29/69	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery	24d. LOCATION (City, town, or county) Boise, Ada. (State) Idaho
DATE REC'D BY LOCAL REG. Sept. 30, 1969	REGISTRAR'S SIGNATURE Mrs. Martin Walmsley	25. EMBALMER Marvin R. Hickkila	LICENSE NO. 515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-9184 BIRTH NO.

RECEIVED OCT 3 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4192
Local Reg. No. 472
Reg. Dist. No. 360

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 516 8th ave. South

3. NAME OF DECEASED (Type or Print)
a. (First): Micheal
b. (Middle): Lee
c. (Last): Wintrode

4. DATE OF DEATH (Month) (Day) (Year): September 24, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 23, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min. 44

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Terry Wintrode — BIRTHPLACE: Nampa, Idaho
14. MOTHER'S MAIDEN NAME: Rebecca Sue Fly — BIRTHPLACE: Nampa, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Mrs John W. Fly — ADDRESS: Nampa, Idaho

7701

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) prematurity - abruptio placenti

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/23/ *, 19* 69 *to* 9/24/ *, 19* 69 *that I last saw the deceased alive on* 9/24/ *, 19* 69 *and that death occurred at* 12:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert K Bonan 053
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 2, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Glen G. Siren
LICENSE NO.: E-498

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Shepherd Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. ~~JUL 2 0 2000~~

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JUL 2 1 2000

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4193
Local Reg. No. 478
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 7 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Kuna
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Dorothy; b. (Middle); c. (Last) Duschka

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 26, 1969.

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 17, 1919.

9. AGE (In years last birthday): 50
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Miles City, Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Marion Middleton
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Vera Wescott
BIRTHPLACE: No Record.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-28-5866

17. INFORMANT'S OWN SIGNATURE: Paul Duschka ADDRESS: Rt. 1 Kuna, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 180X INTRA CRANIAL METASTASIS (PROBABLE) — INTERVAL BETWEEN ONSET AND DEATH: 2 MONTHS

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CARCINOMA OF THE UTERINE CERVIX — 3 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: SEPT. 1966

19b. MAJOR FINDINGS OF OPERATION: EXTENSIVE INVASIVE CARCINOMA

20. AUTOPSY? Yes ☐ No ☒ XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 27, 1969, *to* Sept 25, 1969, *that I last saw the deceased alive on* SEPT. 25, 1969, *and that death occurred at* 12:50 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE: J. David Johnson 854 (Degree or title): M.D.

23b. ADDRESS: CALDWELL, IDAHO

23c. DATE SIGNED: SEPT. 30, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 29, 1969.

24c. NAME OF CEMETERY OR CREMATORY: Marsing-Homedale

24d. LOCATION (City, town, or county) (State): Owyhee County, Idaho

DATE REC'D BY LOCAL REG.: Oct. 6, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Dan D. Sanjanni

LICENSE NO.: E-496

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4194
Local Reg. No. 480
Reg. Dist. No. 360

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 142 OCT 9 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park View Manor 390

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 311 21st Ave. So.

3. NAME OF DECEASED (Type or Print)
a. (First) Hannah
b. (Middle) Jane
c. (Last) Voight

4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Oct. 31, 1887

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Chickopee, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Austin Russell
BIRTHPLACE No Record

14. MOTHER'S MAIDEN NAME No Record
BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 541 30 1842

17. INFORMANT'S OWN SIGNATURE Clifford B. Voight
ADDRESS 1008 Mira Mar Medford Oregon 97501

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C V A — INTERVAL BETWEEN ONSET AND DEATH 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ASHD & long standing — 1 yr.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* Sept 27, 1969, *that I last saw the deceased alive on* 26 Sept, 19 69, *and that death occurred at* 24 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 30, 1969

24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park

24d. LOCATION (City, town, or county) (State) Ada County, Idaho

DATE REC'D BY LOCAL REG. Oct. 8, 1969

REGISTRAR'S SIGNATURE Mrs. Martin Walmsley

25. EMBALMER Glen G. Sirin

LICENSE NO. E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4195
Local Reg. No. 483
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. View Terrace Nursing Home 360

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 124 Dearborn St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Margaret	Catherine	Willson	Sept. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	April 4, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Douglas County, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-16-4639B	Harry E Willson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	486X Pneumonia	4 Days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	CVA	None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug 6, 1968, to Sept, 1969, that I last saw the deceased alive on Sept 25, 1969, and that death occurred at 1:07 p m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul E Reynolds 437	MD	Caldwell Idaho	10-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 2, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 9, 1969	Mrs. Martina Walmsley	Kenneth E Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 19 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4196
Local Reg. No. 473
Reg. Dist. No. 360

69-9198 RECEIVED

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 OCT 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital 050

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 716-7th Street South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Baby Girl		Aldrich	Sept. 28 1969-

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	INFANT	Sept. 28, 1969	--	-- /	4 /

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT 0	-----	Nampa, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jack Aldrich	Rupert, Idaho	Sandra Lynn Epley	Nampa, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	-----	Jack Aldrich	Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 7691 Prematurity

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature rupture of membranes.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/28/ , 19 69 , *to* 9/28/ , 19 69 , *that I last saw the deceased alive on* 9/28/ , 19 69 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert H. Bowman 053	619 So. Canyon, Nampa, Idaho	9/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 1, 1969	Hillcrest Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 2, 1969	Mrs. Martina Walmsley	Richard W. Alsip	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 13 1969

Bureau of Vital Statistics

State File No. 4197
Local Reg. No. 484
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 415 7th Ave. So. 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 415 7th Ave. So.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LILLIE	EDITH	BURT	Sept. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Oct. 8, 1884	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 21	At Home	Fair Play, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John H. Malloy	No Record	Angeline Parker	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-56-7428	Mary a Burt	415 7th ave so Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	1 wk
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral Atherosclerosis + senility	3 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus	2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/15/ 63 *to* 9/28/ 69 *that I last saw the deceased alive on* 9/28/ 69 *and that death occurred at* 9:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Valentine Way MD 217	619 So. Canyon, Nampa, Idaho	10/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 1, 1969	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 9, 1969	Mrs. Martina Walmsley	Richard W. Meadows	E-487

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Alsip Funeral Chapel

OCT 14 1969
JAN 19 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4198
Local Reg. No. 476
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 6 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 6 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION Route 1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edith	Anna	Knigge	September 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Feb. 28, 1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Alexandria, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Eden Sr.	Bruning, Nebraska	Florance Steele	Western, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		NONE	Roy Knigge	Nampa, Ida.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Inspection & History, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 3. A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Weseke 583 M. D. Coroner	Nampa, Idaho	9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 3, 1969	Mrs. Martina Walmsley	J. B. Shepherd	473

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

State File No. 4199
Local Reg. No. 486
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lasher's Blvd. Nursing Home 358

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 316-19th Avenue South

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) Henry
c. (Last) Mapes

4. DATE OF DEATH (Month) (Day) (Year) September 30, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 19, 1876
9. AGE (In years last birthday) 93
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker 21
10b. KIND OF BUSINESS OR INDUSTRY Carpentry
11. BIRTHPLACE (State or foreign country) Wyandotte, Michigan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Silia W. Mapes
BIRTHPLACE New York
14. MOTHER'S MAIDEN NAME Elizabeth Sanker
BIRTHPLACE Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) Spanish-Am. 1
16. SOCIAL SECURITY NO. 375-07-6633
17. INFORMANT'S OWN SIGNATURE Mildred L. Mapes
ADDRESS Nampa

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarct
DUE TO (c) Generalized A-S

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. (d) Old age

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/13/ *, 19*49 *, to* 9/30/ *, 19*69 *, that I last saw the deceased alive on* 9/30/ *, 19*69 *, and that death occurred at* 8:50 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Jos Salter 454 (Degree or title)
23b. ADDRESS Nampa
23c. DATE SIGNED 10/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 2, 1969
24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 9, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 4 1969

NOV 5 1969

NOV 6 1969

JAN 1 5 1981

AUG 1 0 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 6 1969 Bureau of Vital Statistics

State File No. 4200
Local Reg. No. 475
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Mercy Hospital DSD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 908 16th Ave. So.

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) P. c. (Last) O'Malley

4. DATE OF DEATH (Month) (Day) (Year) Sept. 30, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH December, 14, 1897

9. AGE (In years last birthday) 71

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY U.P. Rail Road

11. BIRTHPLACE (State or foreign country) Alda, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William O'Malley
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Mary Fitzgerald
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 712 07 1244

17. INFORMANT'S OWN SIGNATURE X Mrs John O'Malley
ADDRESS Banga

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1890

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary edema
DUE TO (c) Ca of Rt Kidney

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Metastatic Ca of Rt Kidney

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 9

19b. MAJOR FINDINGS OF OPERATION Metastatic Ca of Rt Kidney

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from Jan 1 19 68 to Sept 30, 1969, that I last saw the deceased alive on Sept 30, 1969, and that death occurred at 7:00P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title) 450 MD

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED 10-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-4-69

24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery

24d. LOCATION (City, town, or county) Nampa, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 3, 1969

REGISTRAR'S SIGNATURE Mrs. Martin Walmsley

25. EMBALMER Glen L. Siren

LICENSE NO. E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1969

MAY 2 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 2 5 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4201
Local Reg. No. 8
Reg. Dist. No. 520-521

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Caribou (150) OCT 10 1969
b. CITY OR TOWN Soda Springs
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou Memorial Hospital (069)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Caribou (52)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grace
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Rita Kirby Johnson

4. DATE OF DEATH (Month) (Day) (Year) Sept. 26, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH March 7, 1896

9. AGE (In years last birthday) 73
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife (07)

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Franklin, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward Kirby
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Luella Packer
BIRTHPLACE Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Lucian R Johnson
ADDRESS Grace, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage (4319)
INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1965, *to* Sept 26, 1969, *that I last saw the deceased alive on* Sept 26, 1969, *and that death occurred at* 8:22 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) (534) M.D

23b. ADDRESS Soda Springs Ida

23c. DATE SIGNED 10/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/30/69

24c. NAME OF CEMETERY OR CREMATORY Grace Cemetery

24d. LOCATION (City, town, or county) Grace, Idaho (State)

DATE REC'D BY LOCAL REG. 10-9-69

REGISTRAR'S SIGNATURE Norene Bunn

25. EMBALMER Kenneth Allen

LICENSE NO. E370

FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 17 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4202
Local Reg. No. 2021
Reg. Dist. No. 470

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 160 SEP 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Malta
c. LENGTH OF STAY (If in place): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Hiway # 30 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: Davis 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Layton
d. STREET ADDRESS (If rural, give location): ********

3. NAME OF DECEASED (Type or Print)
a. (First): Eileen
b. (Middle): Rae
c. (Last): Child

4. DATE OF DEATH (Month) (Day) (Year): Sept. 1, 1969

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 7, 1930
9. AGE (In years last birthday): 38 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Gooding, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jack B. Allen — BIRTHPLACE: Hawkins, Idaho
14. MOTHER'S MAIDEN NAME: Cora Lavern Jenkins — BIRTHPLACE: Sugar House Ut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Jack B Allen — ADDRESS: Hagerman Ida

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Frontal skull fracture — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Multiple lacerations & broken bones
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hiway 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rural — Cassia 160 — Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9 1 69 4:15 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile accident

22. *I hereby certify that I attended the deceased from* Abt. *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 4:15 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE: C. Bruce Young 583 4 (Degree or title): Coroner
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 9-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 9/5/69
24c. NAME OF CEMETERY OR CREMATORY: Hagerman Cemetery [redacted]
24d. LOCATION (City, town, or county) (State): Hagerman, Idaho [redacted]

DATE REC'D BY LOCAL REG.: Sept 5 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 30 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

Amended Oct. 23, 1969

Certificate of Death
STATE OF IDAHO

State File No. 4203
Local Reg. No. 2020
Reg. Dist. No. 470

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Cassia 160	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Utah 45 b. COUNTY: Davis 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Malta c. LENGTH OF STAY (In this place): None	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Layton
d. FULL NAME OF HOSPITAL OR INSTITUTION: U. S. Hiway #30 002	d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)	5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Kennen	Ray	Child	Sept. 1, 1969	Male	White	never married	July 26, 1963	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	None	Ogden, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Spencer Child	Clinton, Utah	Eileen Allen	Gooding, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	None	Jack B. Allen	Hagerman, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8191

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Skull Fracture — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple Lacerations
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Hiway 06	Rural Cassia 160 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Sept 1, 1969 - 4:15 p m.		Automobile Accident

22. *I hereby certify that I attended the deceased from* _____ *19____, to* _____ *, 19____, that I last saw the deceased alive on* _____ *, 19____, and that death occurred at* abt 4:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Bruce Young, Coroner 563 4	Burley, Idaho	9-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	9-5-69	Hagerman Cemetery	Hagerman, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 5, 1969	Beth H. Pearson	J. Garth Payne	E 389

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Payne Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of.....
County of..... } ss.

Certificate No.....

Date Filed.....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death) for Kennon Child (Name on Original Certificate) who died (Was Born or Died) on Sept 1, 1969 (Date of Event) in Malta Rural, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by.....(Bible Record, Insurance Policy, Etc.) prepared on.....(Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name of Child	Kennon Child	Kennen Ray Child
Date of Birth	1964	July 26, 1963
Age	5	6

Subscribed and sworn to before me this.....day of .....19.....

.....
Notary Public, residing at.....
My commission expires.....
(Seal)

Signed Kennen R. Child
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

.....
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of.....
County of..... } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this.....day of .....19.....

.....
Notary Public, residing at.....
My commission expires.....
(Seal)

Signed Gerald R. Thomson
(Signature of Any Credible Person)

1095 No. Main Layton, Utah
(Street Address, City, State)

FORM DH 60-155

L. 9-31-67

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 8 1969 Bureau of Vital Statistics

State File No.
Local Reg. No. 2020
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Malta
c. LENGTH OF STAY (in this place): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Hiway # 30

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah
b. COUNTY: Davis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Layton
d. STREET ADDRESS (If rural, give location): *********

3. NAME OF DECEASED (Type or Print)
a. (First): Kennon
b. (Middle):
c. (Last): Child

4. DATE OF DEATH (Month) (Day) (Year): Sept. 1, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: 1964
9. AGE (In years last birthday): 5 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Ogden, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Spencer Child - Clinton, Utah
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Eileen Allen - Gooding, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: Jack B Allen — ADDRESS: Hagerman Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull Fracture — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple lacerations
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hiway
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rural Cassia Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9 1 1969 4:15 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile accident

22. *I hereby certify that I attended the deceased from* Abt. 4:15p *19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 4:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Bruce Young Coroner
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 9-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9/5/69
24c. NAME OF CEMETERY OR CREMATORY: Hagerman Cemetery [redacted]
24d. LOCATION (City, town, or county) (State): Hagerman, Idaho [redacted]

DATE REC'D BY LOCAL REG.: Sept 5, 1969
REGISTRAR'S SIGNATURE: Bud N. Pearson
25. EMBALMER: Garth Schepel
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 24 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

BIRTH NO.

State File No. 4204
Local Reg. No. 2025
Reg. Dist. No. 470

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 161 — SEP 17 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY IN (this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1660 Monroe

3. NAME OF DECEASED (Type or Print): a. (First) Elizabeth — b. (Middle) — c. (Last) Miller

4. DATE OF DEATH: (Month) Sept. (Day) 9, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: November 9, 1890

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Hillsboro, Tenn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joe Willis — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Lenora Marshall — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 518-30-1956

17. INFORMANT'S OWN SIGNATURE: Willis Miller — ADDRESS: Burley, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Arteriosclerotic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4705

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Acute Myocardial Infarct — 2 Hrs
DUE TO (c): Mitral Stenosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Hypertension

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-8-69 *to* 9-9, 1969, *that I last saw the deceased alive on* 9-9, 19 69, *and that death occurred at* 1:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. D. Kelly 276 — **23b. ADDRESS**: Burley — **23c. DATE SIGNED**: 9-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 9/12/69 — **24c. NAME OF CEMETERY OR CREMATORY**: Pleasant View — **24d. LOCATION** (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept. 15 1969 — REGISTRAR'S SIGNATURE: Beth N. Pearson

25. EMBALMER — LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4205
Local Reg. No. 2026
Reg. Dist. No. 470

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia (16) — SEP 17 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY IN (this place): Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burley Nursing Home (290)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia (16)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): R.F.D. 700 E. 500 S.

3. NAME OF DECEASED (Type or Print): a. (First) Frank — b. (Middle) Harold — c. (Last) Weeks

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 10, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 20, 1887

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dentist 15

10b. KIND OF BUSINESS OR INDUSTRY: Dentistry

11. BIRTHPLACE (State or foreign country): Pleasant Grove, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Reuben Weeks — BIRTHPLACE: Irenisent, Iowa

14. MOTHER'S MAIDEN NAME: Mary Lucinda Hurst — BIRTHPLACE: Springville, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. #1

16. SOCIAL SECURITY NO.: 518-12-1800-A

17. INFORMANT'S OWN SIGNATURE: Mrs. Frank H. Weeks — ADDRESS: Burley, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate & Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1-3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1857

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-17-46, 19___, *to* 9-10-69, 19___, *that I last saw the deceased alive on* 9-4-69, 19___, *and that death occurred at* 2:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 526. (Degree or title) MD

23b. ADDRESS: Burley Idaho

23c. DATE SIGNED: 9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/13/69

24c. NAME OF CEMETERY OR CREMATORY: Gem Memorial Gardens

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept. 16, 1969

REGISTRAR'S SIGNATURE: Ruth N. Pearson

25. EMBALMER: [signature]

LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4206
Local Reg. No. 2028
Reg. Dist. No. 470

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 23 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley,
c. LENGTH OF STAY (If not in this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 870

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert rural
d. STREET ADDRESS (If rural, give location): Jackson District

3. NAME OF DECEASED (Type or Print)
a. (First): Henry
b. (Middle):
c. (Last): Neilson

4. DATE OF DEATH (Month) (Day) (Year): Sept. 13, 1969

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 12, 1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months 7, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-stockman 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): LaJara, Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Gerrion Neilson, Copenhagen, Denmark
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Mary Simpson, Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: 519-40-6234A
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Merab Neilson Rupert Idaho R1 83350

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vacc. Accident — INTERVAL BETWEEN ONSET AND DEATH: 9 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Myocarditis — ✓
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Dementia — ✓

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-1, 1968, *to* 9-13-, 1969, *that I last saw the deceased alive on* 9-13-, 1969 *and that death occurred at* 1 15 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 276 MD
23b. ADDRESS: Burley Ida
23c. DATE SIGNED: 9-16-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept. 22 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4207
Local Reg. No. 2029
Reg. Dist. No. 470

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 23 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township or other place): Declo - rural
c. LENGTH OF TIME (If outside corporate limits, write RURAL and give township or other place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4 mi.east Declo 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert - rural
d. STREET ADDRESS (If rural, give location): 082 E. 100 S.

3. NAME OF DECEASED (Type or Print)
a. (First): Albert
b. (Middle):
c. (Last): Silversmith

4. DATE OF DEATH (Month) (Day) (Year): Sept. 14, 1969

5. SEX: male
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 20, 1931
9. AGE (In years last birthday): 38 — IF UNDER 1 YEAR: Months 4, Days 25 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Mexico
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jack Silversmith — BIRTHPLACE: New Mexico
14. MOTHER'S MAIDEN NAME: No data — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: 525-64-1098
17. INFORMANT'S OWN SIGNATURE: Tony Joe Rt. 1 Rupert, Idaho — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

968X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Ba sal skull fracture caused by blow with heavy blunt instument — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 3 H omicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Unknown 00
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): believed rural Cassia 160 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-14-69 Unknown
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Beating about head & face

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* unknown *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C Bruce Young Coroner 583-4
23b. ADDRESS: B urle y, Idaho
23c. DATE SIGNED: 9-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Sept.19,1969
24c. NAME OF CEMETERY OR CREMATORY: Houck Cemetery
24d. LOCATION (City, town, or county) (State): Houck, Arizona

DATE REC'D BY LOCAL REG.: Sept 22 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Armand F. Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 4208
Local Reg. No. 2027
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia 161 SEP 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
DURATION OF STAY (in this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 010

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 719 Elba Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Glenn	Stewart	Jordan	Sept. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Feb. 4, 1927	42				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY ********
11. BIRTHPLACE (State or foreign country) Castle Gate, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE Stewart Elliott Jordan-Springville, Ut.
14. MOTHER'S MAIDEN NAME BIRTHPLACE Laura Viola Glenn - Albion, Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. #2
16. SOCIAL SECURITY NO. 518-22-8175
17. INFORMANT'S OWN SIGNATURE Mrs Clara Jordan ADDRESS Burley, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema - Cor Pulmonale
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocarditis
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-11-, 1969, *to* 9-15-, 1969, *that I last saw the deceased alive on* 9-15, 1969, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M D
23b. ADDRESS Burley
23c. DATE SIGNED Sept. 18-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 9/18/69
24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery
24d. LOCATION (City, town, or county) (State) Heyburn, Idaho

DATE REC'D BY LOCAL REG. Sept 22 1969
REGISTRAR'S SIGNATURE Burt N. Pearson
25. EMBALMER
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4209
Local Reg. No. 2030
Reg. Dist. No. 470

RECEIVED
SEP 29 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley rural
c. LENGTH OF STAY (in this place): 56 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Moulton area 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley rural
d. STREET ADDRESS (If rural, give location): Moulton area

3. NAME OF DECEASED (Type or Print)
a. (First): Adeline
b. (Middle): Matilda
c. (Last): Bullers

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 17, 1903
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months 9, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 0'
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Uintah, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Henry Elisha Millard, Uintah, Utah
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Elizabeth Ann Saunders, Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Chester Bullers Oakley Ida.

4299

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* abt. 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Bruce Young 533 4 Coroner
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 23, 1969
24c. NAME OF CEMETERY OR CREMATORY: Bullers Cemetery
24d. LOCATION (City, town, or county) (State): Moulton, Cassia Co., Idaho

DATE REC'D BY LOCAL REG.: Sept 25 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F. Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 7 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4210
Local Reg. No. 2031
Reg. Dist. No. 470

BIRTH NO. 69-9241

RECEIVED SEP 29 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia (16)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia (16)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 172 Schodde Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Rachel b. (Middle) Ann c. (Last) Keys

4. DATE OF DEATH: (Month) Sept. (Day) 19, (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Sept. 18, 1969

9. AGE (In years last birthday): Months | Days | IF UNDER 1 YEAR | IF UNDER 24 HRS. Hours 1 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Burley, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Peter L. Keys — BIRTHPLACE: Oberlin, Ohio

14. MOTHER'S MAIDEN NAME: Karel A. Farnsworth — BIRTHPLACE: Los Angeles, Cal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S SIGNATURE: Peter L. Keys — ADDRESS: Burley, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Marked Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-18, 1969, *to* 9-19, 1969, *that I last saw the deceased alive on* 9-18, 1969, *and that death occurred at* 4:50 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. — **23b. ADDRESS**: Burley, Idaho — **23c. DATE SIGNED**: 9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 9/22/69 — **24c. NAME OF CEMETERY OR CREMATORY**: Gem Memorial Gardens — **24d. LOCATION** (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept 26, 1969 — REGISTRAR'S SIGNATURE: Bette N. Pearson

25. EMBALMER: [signature] — LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4211
Local Reg. No. 2035
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 20 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 970

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paul
d. STREET ADDRESS (If rural, give location): R.F.D. # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Christoph
b. (Middle): J.
c. (Last): Hansen

4. DATE OF DEATH (Month) (Day) (Year): Sept, 27, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 28, 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Cattleman 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Raymond, Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ernest J. Hansen — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Maria Bodenstiener — BIRTHPLACE: Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-42-7095
17. INFORMANT'S OWN SIGNATURE: Mrs. Chris J. Hansen — ADDRESS: Paul, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/09

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis Rt Auricle — INTERVAL BETWEEN ONSET AND DEATH: 20 Sept 69

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Resulting in Rupture — 26 Sept 69
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-28-67, 19__, *to* 9-27-69, 19__, *that I last saw the deceased alive on* 9-15-69, 19__, *and that death occurred at* 9:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 526 (Degree or title)
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 1 Oct '69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10/1/69
24c. NAME OF CEMETERY OR CREMATORY: Paul Cemetery
24d. LOCATION (City, town, or county) (State): Paul, Idaho

DATE REC'D BY LOCAL REG.: Oct. 17 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 21 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 12 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
OCT 7 1969
BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 4212
Local Reg. No. 2031
Reg. Dist. No. 470

Bureau of Vital Stat

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hosp. 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1559 Miller Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Oscar
b. (Middle): B.
c. (Last): Johnson

4. DATE OF DEATH (Month) (Day) (Year): Sept. 27, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 19, 1922
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: ********
11. BIRTHPLACE (State or foreign country): Huntsville, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Wesley Johnson — BIRTHPLACE: Quincy, Illinois
14. MOTHER'S MAIDEN NAME: Luvene McCollum — BIRTHPLACE: Keytesville, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 487-20-0535
17. INFORMANT'S OWN SIGNATURE: X Mrs Evelyn Johnson — ADDRESS: Burley, Idaho

1703

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chondrosarcoma of chest wall — INTERVAL BETWEEN ONSET AND DEATH: 1967

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8-10-67
19b. MAJOR FINDINGS OF OPERATION: Chondrosarcoma 5th rib right chest wall
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-18-67, 19__, *to* 9-27-69, 19__, *that I last saw the deceased alive on* 9-26-69, 19__, *and that death occurred at* 5:05 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 239 (Degree or title) M.D.
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9/30/69
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Oct 3 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

State File No. 4213
Local Reg. No. 57
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 18
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (In this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: State Hosp. North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Wash 48
b. COUNTY: Spokane 255
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): E. 13 Augusta

3. NAME OF DECEASED (Type or Print): a. (First) Charles b. (Middle) Edward c. (Last) Bowers

4. DATE OF DEATH: (Month) Sept (Day) 11 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 12 1916

9. AGE (In years last birthday): 53

IF UNDER 1 YR. Months | Days

IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance 06

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): WASHINGTON

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Bowers
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Ella Baker
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II 4

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Mrs. Bowers
ADDRESS: E. 13 Augusta

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8847

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute cerebral hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Traumatic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT [X] / SUICIDE [ ] / HOMICIDE [ ] (Specify): Accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Public restaurant 17

21c. (CITY, TOWN, OR TOWNSHIP): Orofino 180 (COUNTY): Clearwater (STATE): Idaho

21d. TIME OF INJURY: (Month) September (Day) 10, (Year) 1969 (Hour) 6 pm m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR? Fall from stool

22. *I hereby certify that I attended the deceased from* never *, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 4:45 p m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 4 (Degree or title): Coroner

23b. ADDRESS: Orofino, Idaho

23c. DATE SIGNED: 9/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Sept 12 1969

24c. NAME OF CEMETERY OR CREMATORY: Sherman Funeral Home

24d. LOCATION (City, town, or county) (State): Newport, Wash.

DATE REC'D BY LOCAL REG.: September 18, 1969

REGISTRAR'S SIGNATURE: Irene M. Burger

25. EMBALMER: [signature]

LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 24 1969
FEB 11 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
SEP 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4214
Local Reg. No. 58
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 7 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elk River
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): ARCHIE
b. (Middle):
c. (Last): NEWCOMB

4. DATE OF DEATH (Month) (Day) (Year): September 23, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 11, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac A. Newcomb — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Caroline A. Wescott — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 518-18-9614
17. INFORMANT'S OWN SIGNATURE: Christine Plaurde — ADDRESS: Records Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Advanced arteriosclerosis — Several years
DUE TO (c): Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-22-69, 19__, *to* 9-23, 1969, *that I last saw the deceased alive on* 9-23-, 1969, *and that death occurred at* 3:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): Carlos Fernandez-Leon, M.D. 592 [signature]
23b. ADDRESS: 1018 9th St. Clarkston, Wash
23c. DATE SIGNED: 9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 25, 69
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Sept. 24, 1969
REGISTRAR'S SIGNATURE: Lerw M. Burger
25. EMBALMER: [signature] — LICENSE NO.: 476
FIRM NAME: Gilbert's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4215
Local Reg. No. 8
Reg. Dist. No. 680

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Custer 190
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clayton
LENGTH OF STAY (in this place): 27 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 007

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clayton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Phileomene	Josephine	Judd	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Sept. 14, 1916	52				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
home 01		Salt Lake City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Roscoe	Minnesota	Amelia Leonard	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-54-3405	Bennie C. Judd	Clayton, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction, Presumed — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/22, 19 68, *to* 7/19, 1969, *that I last saw the deceased alive on* 7/19, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

22a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marcus Petersen 152 MD	Sun Valley Idaho	9/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 5, 1969	Challis	Challis, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/16/69	Lawton J. Mulder	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME, Salmon

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

68-12249 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4216
Local Reg. No. 57
Reg. Dist. No. 380 391

BIRTH NO.

SEP 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Elmore Mem. Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 835 So. 3rd W. A

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RENIE	DAWN	MAYEAUX	August 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	never married	Dec. 27, 1969		8			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mountain Home AFB, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wayne E. Mayeaux	Louisiana	Linda C. Anders	Louisiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Wayne E. Mayeaux ADDRESS: Mt. Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4868

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Congestion (Crib Death)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Unknown Etiology
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation that I saw the deceased *alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur Smith SR3	Coroner 4.	Mountain Home, Idaho	8/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8/28/69	Pineville, Louisiana	Pineville, Louisiana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 16 1969	A. Anderson	H. Dud Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4217
Local Reg. No. 59
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Mountain Home 200
SEP 25 1969
Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Rest Home 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Mountain Home
d. STREET ADDRESS (If rural, give location): 2 miles So. Mtn. Home

3. NAME OF DECEASED (Type or Print)
a. (First): HENRY
b. (Middle): JAMES
c. (Last): LEMMON

4. DATE OF DEATH (Month) (Day) (Year): September 5, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 12, 1891
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Weston, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Lemmon — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Margret McCulloch — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War 1 3
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: David Lemmon — ADDRESS: Potter Valley Calif.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

~~DUE TO~~ (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diabetes Mel & Arteriosclerotic H. dis. years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967, *to* Sept. 5, 1969, *that I last saw the deceased alive on* Sept 4, 1969, *and that death occurred at* 1:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Malone W. Loelsch M.D. 289 (Degree or title)
23b. ADDRESS: Mountain Home Idaho
23c. DATE SIGNED: Sept 12 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/8/69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Sept 16 1969
REGISTRAR'S SIGNATURE: A. Anderson
25. EMBALMER: H. Neil Humphreys
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
*(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4218
Local Reg. No. 63
Reg. Dist. No. 380-391

RECEIVED OCT 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rrual - Mtn. Home
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ¼ mile West on Sawtooth Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Mtn. Home
d. STREET ADDRESS (If rural, give location) ¼ mile West on Sawtooth Mill Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GLENN	LEROY	WELLS	September 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	Dec. 7, 1917	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician 21		Dallas Center, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes World War 11	535-12-1383	Mrs. Ralph Pierce	Mt. Home, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur Smith	S B 4 Coroner	Mountain Home, Idaho	9/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/22/69	Mtn. View Cemetery	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 9 1969	[signature]	[signature]	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4219
Local Reg. No. 64
Reg. Dist. No. 380 391

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Elmore 200 OCT 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenns Ferry
d. STREET ADDRESS (If rural, give location) Glenns Ferry

3. NAME OF DECEASED (Type or Print): a. (First) DWIGHT b. (Middle) WILLIAM c. (Last) CORGAN

4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 15, 1892

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 28

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Tammara, Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Corgan
BIRTHPLACE

14. MOTHER'S MAIDEN NAME
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE ADDRESS: ELMORE MEM. HOSPITAL RECORDS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1890

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastatic Ca of Kidney
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/25/69

24c. NAME OF CEMETERY OR CREMATORY: Glenn Rest Cemetery

24d. LOCATION (City, town, or county) (State): Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.: Oct 9 1969

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature]

LICENSE NO.: E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: APR 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4220
Local Reg. No. 60
Reg. Dist. No. 389 391

BIRTH NO.

RECEIVED OCT 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn Home AFB
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 67 Tac Hosp, Mt Home AFB, ID

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn Home AFB
d. STREET ADDRESS (If rural, give location): 4655A Magnolia

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JASON	KERR	PLEWNIAK	September 25 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cau	Never Married	17 Sep 66	3				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
02		Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dennis P. Plewniak, Buffalo, New York		Sharon M. Babey	Lloydminster - Saskatchewan, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Official Medical Records	4655A Magnolia Mt Home ID

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4823

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Staphyloccal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Massive Aspiration
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 22 Sep, 1969, *to* 25 Sep, 1969, *that I last saw the deceased alive on* 24 Sep 1969, *and that death occurred at* 0200 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
EDWARD L. CHARNOCK, CAPT, USAF, MC 585 MD	Mtn Home AFB, Idaho	25 Sep 69

24a. BURIAL CREMATION REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
B	9/27/69 Removal - 9/27/69	Lloydminster, Canada	Lloydminster, Sask., Canada

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 2 1969			E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-8182 BIRTH NO.

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4221
Local Reg. No. 65
Reg. Dist. No. 380 391

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Elmore 300 OCT 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Home AFB
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 67 Tac Hosp, Mt Home AFB, ID 837

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Home AFB
d. STREET ADDRESS (If rural, give location) 4767B Tamarack

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CAROLYN	MIRIAM	WILBOURN	Sep 25 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cau	Never Married	25 Aug 69			32		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
02		Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elsmere Allen Wilbourn/So. Boston, Va		Daphne May Route	Kings Lynn, Norfolk, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Official Medical Records	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Overwhelming Sepsis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity — 32 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 25 AUG, 19 69, *to* 25 Sept, 19 69, *that I last saw the deceased alive on* 25 Sept, 19 69 *and that death occurred at* 5 5-2 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward L Clarnon, USAF MC	Mtn Home AFB, Idaho	25 Sep 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/27/69	Mtn. View Cemetery	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 9 1969	[signature]	Arthur Smith	E-403

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Mortuary

OCT 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4222
Local Reg. No. 66
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 100 Mtn. View Drive

3. NAME OF DECEASED (Type or Print)
a. (First): MRS. DIXIE
b. (Middle): ALICE BROWN
c. (Last): VOGEL

4. DATE OF DEATH (Month) (Day) (Year): September 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 7, 1916
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Mountain Home, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William B. Brown — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Gladys Loverridge — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 549-01-0753
17. INFORMANT'S OWN SIGNATURE: Michael C. Vogel — ADDRESS: L.A., CALIF.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 8, 1969, *to* Sept 28, 1969, *that I last saw the deceased alive on* Sept 27, 1969, *and that death occurred at* 6:05 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Malone N. Koch, M.D. 289
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: Oct 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/1/69
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Oct 9 1969
~~REGISTRAR'S SIGNATURE~~: C. Anderson
25. EMBALMER: H. Earl Humphrey
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 15 1969

SEP 6 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4223
Local Reg. No. 10
Reg. Dist. No. 540

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
SEP 22 1969

1. PLACE OF DEATH

a. COUNTY Franklin 210

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Franklin

c. LENGTH OF STAY (In this place) 56 yrs

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 207 East 1st North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY Franklin 210

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Franklin

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)

a. (First) ROBERT b. (Middle) ANDREW c. (Last) MORRISON

4. DATE OF DEATH (Month) (Day) (Year) September 4, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH September 26, 1912

9. AGE (In years last birthday) 56

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Franklin, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alma Morrison

BIRTHPLACE Cove, Utah

14. MOTHER'S MAIDEN NAME Amy Leah Gregory

BIRTHPLACE Cove, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 519 10 7807

17. INFORMANT'S OWN SIGNATURE Joseph D. Morrison

ADDRESS Franklin, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 485X Bronchial Pneumonia

INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death* Chronic Myelocytic Leukemia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1965, *to* Death, 1969, *that I last saw the deceased alive on* 8-25, 1969, *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Merrill C Hansen 229 **(Degree or title)** M.D

23b. ADDRESS Logan Utah

23c. DATE SIGNED 10 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 8, 1969

24c. NAME OF CEMETERY OR CREMATORY Franklin Cemetery

24d. LOCATION (City, town, or county) Franklin, Idaho (State)

DATE REC'D BY LOCAL REG. 9-8-69

REGISTRAR'S SIGNATURE Eppie W. Brewer

25. EMBALMER Douglas S. Webb

LICENSE NO. 488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 2 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4224
Local Reg. No. 11
Reg. Dist. No. 5440

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 211
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 236 Park Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) DAVID
b. (Middle) ARIEL
c. (Last) NASH

4. DATE OF DEATH (Month) (Day) (Year) Sept. 8, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Feb. 14, 1902

9. AGE (In years last birthday) 67
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Fieldman 24

10b. KIND OF BUSINESS OR INDUSTRY Amalgamated Sugar Co.

11. BIRTHPLACE (State or foreign country) Franklin, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David H. Nash
BIRTHPLACE Franklin, Idaho

14. MOTHER'S MAIDEN NAME Ida Larson
BIRTHPLACE Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 24 9705

17. INFORMANT'S OWN SIGNATURE O. A. Nash Jr.
ADDRESS Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Bowel Obstruction — 24 Hrs.

DUE TO (c) Intestinal lymphangiectasia — 1 Year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1954, *to* Sept. 8, 1969, *that I last saw the deceased alive on* Sept 7, 1969, *and that death occurred at* 2 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE Leo R. Hawkes 214 (Degree or title) M.D.

23b. ADDRESS Preston. Idaho

23c. DATE SIGNED 9/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 11, 1969

24c. NAME OF CEMETERY OR CREMATORY Framklin Cemetery

24d. LOCATION (City, town, or county) (State) Franklin, Idaho

DATE REC'D BY LOCAL REG. 9-11-69

REGISTRAR'S SIGNATURE Effie W. Brower

25. EMBALMER Douglas S. Webb — LICENSE NO. 488

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 11 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 19 1986

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4225
Local Reg. No. 12
Reg. Dist. No. 340

BIRTH NO.

RECEIVED OCT 23 1969

1. PLACE OF DEATH
a. COUNTY Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial Hospital 181

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weston
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) HULDA
b. (Middle) LUNDQUIST
c. (Last) NELSON

4. DATE OF DEATH (Month) (Day) (Year) Sept 21, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widdowed
8. DATE OF BIRTH Jan 19, 1879
9. AGE (In years last birthday) 90 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Weston, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Axel Theodor Lundquist — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Sarah Anders Erson — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE X Roma Hall — ADDRESS Fairview, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arteriosclerosis — 10 yr

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1966, *to* Sept 21, 1969 *that I last saw the deceased alive on* Sept 21, 1969, *and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23a. SIGNATURE C R Cutler 122 (Degree or title) MD
23b. ADDRESS Preston Idaho
23c. DATE SIGNED Sept. 22, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept 24, 1969
24c. NAME OF CEMETERY OR CREMATORY Weston Cemetery
24d. LOCATION (City, town, or county) (State) Weston, Idaho

DATE REC'D BY LOCAL REG. Sept 24, 69
REGISTRAR'S SIGNATURE Eggie W. Brower
25. EMBALMER Douglas S. Webb — LICENSE NO. 488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

JUN 29 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4226
Local Reg. No. 34
Reg. Dist. No. 650

RECEIVED
221 SEP 23 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): 303 West Main

3. NAME OF DECEASED (Type or Print): a. (First) ANNA b. (Middle) CHRISTINA c. (Last) MADSEN THORSTED

4. DATE OF DEATH (Month) (Day) (Year): Sept., 9, 1969

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: June 21, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hyrum, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Madsen
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Mary Ann Hansen
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-07-0563

17. INFORMANT'S OWN SIGNATURE: Hazel M. Brookhart
ADDRESS: Salt Lake City Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CHF — 10 d
DUE TO (c) ASHD — 4 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept 8, 1969 *to* Sept 9, 1969, *that I last saw the deceased alive on* Sept 9, 1969, *and that death occurred at* 12:15AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Floyd Barrett MD 030
23b. ADDRESS: St. Anthony, Idaho
23c. DATE SIGNED: 11 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12 Sept 69
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton Fremont, Idaho

DATE REC'D BY LOCAL REG.: 12 Sept 69
REGISTRAR'S SIGNATURE: M. L. Hansen
25. EMBALMER: M. L. Hansen
LICENSE NO.: E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4227
Local Reg. No. 40
Reg. Dist. No. 651

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (In this place): 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Idaho~~ Ashton
d. STREET ADDRESS (If rural, give location): none given

3. NAME OF DECEASED (Type or Print)
a. (First): Paul
b. (Middle): John
c. (Last): Garz

4. DATE OF DEATH (Month) (Day) (Year): Sept 14, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct 31, 1896
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Hoskins, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: August Garz — BIRTHPLACE: Pommern, Germany
14. MOTHER'S MAIDEN NAME: Albertina Lenz — BIRTHPLACE: Stetten, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): m — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 518-34-9407
17. INFORMANT'S OWN SIGNATURE: Mrs Paul Garz — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Recurrent coronary insufficiency — 1 ms.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic coronary heart disease — 1 year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1969, *to* Sept 14, 1969, *that I last saw the deceased alive on* Sept 13, 1969, *and that death occurred at* 5:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 298
23b. ADDRESS: ASHTON - IDAHO
23c. DATE SIGNED: 9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Idaho

DATE REC'D BY LOCAL REG.: 10 Oct 69
REGISTRAR'S SIGNATURE: M L Hansen
25. EMBALMER: [signature]
LICENSE NO.

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 30 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 13 1975

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4228
Local Reg. No. 33
Reg. Dist. No. 651

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY (220) Fremont — SEP 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) (Rural) Ashton
c. LENGTH OF STAY (In this place) Min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY (220) Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby
d. STREET ADDRESS (If rural, give location) 119 N. 2nd West

3. NAME OF DECEASED (Type or Print) — a. (First) MARION — b. (Middle) LYLE — c. (Last) WHITING

4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec. 23, 1906

9. AGE (In years last birthday) 62 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager (26)

10b. KIND OF BUSINESS OR INDUSTRY Co-op Oil Co.

11. BIRTHPLACE (State or foreign country) Wallsburg, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Francis Marion Whiting — BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Mary Davis — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-09-3202

17. INFORMANT'S OWN SIGNATURE Mrs Lyle Whiting — ADDRESS 119 N. 2nd W. Rigby

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8320

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Snake R. (18)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 2mi. N. of Warm River (220) Fremont Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 14 1969 2:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Fell out of boat.

22. *I hereby certify that I attended the deceased from* DOA, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 2:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE Paul Cornell (583 4) (Degree or title) Coroner

23b. ADDRESS Box 170, St. Anthony, Ida.

23c. DATE SIGNED 9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept 17, 1969

24c. NAME OF CEMETERY OR CREMATORY Rigby Pioneer

24d. LOCATION (City, town, or county) Rigby (State) Idaho

DATE REC'D BY LOCAL REG. 18 Sept 69

REGISTRAR'S SIGNATURE M. L. Hansen

25. EMBALMER Bruce A. Eckersell — LICENSE NO. E-404

FIRM NAME: Eckersell Memorial CHapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4229
Local Reg. No. 36
Reg. Dist. No. 651

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 220 Fremont SEP 23 1969
b. CITY OR TOWN St. Anthony-Rural
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) RFD#2 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony-Rural
d. STREET ADDRESS (If rural, give location) RFD#2

3. NAME OF DECEASED (Type or Print) a. (First) ORAL b. (Middle) MARION c. (Last) McMINN

4. DATE OF DEATH (Month) (Day) (Year) Sept 17, 1969

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept., 26, 1912

9. AGE (In years last birthday) 56 | IF UNDER 1 YEAR Months 11 Days 21 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Own Farm

11. BIRTHPLACE (State or foreign country) St. Anthony, RFD#2 (Egin) Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leonard McMinn
BIRTHPLACE Egin, Idaho

14. MOTHER'S MAIDEN NAME Sarah Broadhurst
BIRTHPLACE Egin, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE -Jerry McMinn ADDRESS St. Anthony, RFD#2 Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH: dead on arrival

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: June 1st

19b. MAJOR FINDINGS OF OPERATION: Had mesenteric obstruction 14 feet of bowel removed

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1969, *to* Sept 16, 1969, *that I last saw the deceased alive on* Sept 16, 1969, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M. D. Burley 442

23b. ADDRESS Rexburg Idaho

23c. DATE SIGNED 9-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 18 Sept 69

24c. NAME OF CEMETERY OR CREMATORY Parker Cemetery

24d. LOCATION (City, town, or county) (State) Parker, Fremont County, Idaho

DATE REC'D BY LOCAL REG. 19 Sept 69

REGISTRAR'S SIGNATURE M. D. Hansen

25. EMBALMER M. D. Hansen

LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 22 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
BIRTH OCT 1 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4230
Local Reg. No. 38
Reg. Dist. No. 651

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 053

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chester- Rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) EARL; b. (Middle) HEBER; c. (Last) POTTER

4. DATE OF DEATH: (Month) Sept., (Day) 24, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb., 9, 1884

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (State or foreign country): Albion, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Heber Carlos Potter — BIRTHPLACE: Springville, Utah

14. MOTHER'S MAIDEN NAME: Julia Huffines — BIRTHPLACE: Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-42-9042

17. INFORMANT'S OWN SIGNATURE: Earl J. Potter — ADDRESS: Chester, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease, chronic — 3 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about house, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-15, 1969, *to* 9-24-, 1969, *that I last saw the deceased alive on* 9-23, 1969, *and that death occurred at* 6 PM *from the causes and on the date stated above.*

23a. SIGNATURE: M. D. Hansen (Degree or title): 298
23b. ADDRESS: Ashton Idaho
23c. DATE SIGNED: 29 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 27 Sept 69
24c. NAME OF CEMETERY OR CREMATORY: Wilford Cemetery
24d. LOCATION (City, town, or county) (State): St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.: 29 Sept 69
REGISTRAR'S SIGNATURE: M. D. Hansen
25. EMBALMER: M. D. Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

DUTIES:

OCT 1 1969

NOV 12 1969

FEB 28 1985

JUL 21 1994

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

R

1 copy

RECEIVED Certificate of Death

STATE OF IDAHO

State File No. 4231
Local Reg. No. 9
Reg. Dist. No. 340 341

BIRTH NO.

SEP 8 1969

Bureau of Vital Statistics

231

1. PLACE OF DEATH
a. COUNTY: Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Mem. Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 406 No. Boise

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Minnie	Mary	Bolinger	Sept 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	July 11, 1890	79	1	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Hastings, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John E. Whitright	Unknown	Bessie Howard	Barry Co., Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-12-1455	Stanley H Bolinger	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	ACUTE MYOCARDIAL INFARCTION	IMMEDIATELY
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	SEVERE SECONDARY ANEMIA DUE HEMORRHAGE FROM GASTRO-INTESTINAL TRACT	2 WEEKS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19 50, *to* Sept 3, 19 69, *that I last saw the deceased alive on* Sept 2, 19 69, *and that death occurred at* 3:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Forrest P Fairbairn MD 429	Emmett Idaho	Sept 4 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 5, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 4, 1969	Jean A. Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4232
Local Reg. No. 1C
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231 SEP 1 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 1½ months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 085 Walter Knox Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Mounted Route West 4th.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GEORGE	T.	ELLISON	Sept. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 9, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stockman	Cattle	Gooding, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas P. Ellison	Unknown	Lola Hayden	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		X Hazel J. Ellison	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

185 X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of the prostate with metastases

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March 14 *1969, to* Sept 3 *, 1969, that I last saw the deceased alive on* Sept 3 *, 1969, and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B. Jewell MD 760	1024 E. Locust, Emmett, Idaho	9-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/6/69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-14-69	Jean A. Bradley	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4233
Local Reg. No. 11
Reg. Dist. No. 340-341

RECEIVED STATE OF IDAHO

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231 SEP 16 1969
b. CITY OR TOWN Emmett
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION Walter Knox Memorial Hosp 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gem 231
c. CITY OR TOWN Emmett
d. STREET ADDRESS (If rural, give location) P. O. Box 544

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Calvin	Johnson	Sept. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	June 29, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 07	farm	Elgin, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Charles Johnson	Kansas	Minnie Hill	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	441-05-6054	X Violet Sill	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 9-10, 1969, *that I last saw the deceased alive on* 9-10, 1969, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Emmett, Ida	13 Sept. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 13, 1969	Emmett Cemetery	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 13 1969	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4234
Local Reg. No. 14
Reg. Dist. No. 340, 341

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 7 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 712 So. Boise 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 721 So. Boise

3. NAME OF DECEASED (Type or Print)
a. (First): Clifford
b. (Middle): Woodrow
c. (Last): Jordan

4. DATE OF DEATH (Month) (Day) (Year): Sept. 10, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH: Feb. 11, 1913
9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months ~~6~~ Days ~~29~~
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: cattle
11. BIRTHPLACE (State or foreign country): Westfall, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Chester Warren Jordan
BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Annie Franks
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-12-7780 HA
17. INFORMANT'S OWN SIGNATURE: Farrell F. Jordan
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Cardiac arrhythmia
INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cor pulmonale
mos-yrs.

DUE TO (c) Chronic pulmonary emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Temporal skull fracture, right, acute
Subdural hematoma, left & fractured less than 48 hrs.
ribs, left.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Also fatty metamorphosis of the liver.
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): unknown
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I ~~attended~~ autopsied the deceased ~~from~~ on 9-11, 1969, ~~to~~ ____, 19__, ~~that I last saw the deceased alive on~~ ____, 19__, ~~and that death occurred at~~ ____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 329 Fifth Ave.
23b. ADDRESS: 506 N. 5th St. Boise Idaho
23c. DATE SIGNED: 9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: 9-18-69
REGISTRAR'S SIGNATURE: Juan A. Beatty
25. EMBALMER: [signature]
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4235
Local Reg. No. 12
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231 SEP 1 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 21/2yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 910 East 2nd St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 910 East 2nd St.

3. NAME OF DECEASED (Type or Print) a. (First) Agnes b. (Middle) Jeanette c. (Last) Dummer

4. DATE OF DEATH (Month) (Day) (Year) September 11, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH May 28, 1875

9. AGE (In years last birthday) 94
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse 13

10b. KIND OF BUSINESS OR INDUSTRY nursing

11. BIRTHPLACE (State or foreign country) Grantsville, Utah

12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Elam W. McBride
BIRTHPLACE Grantsville, Utah

14. MOTHER'S MAIDEN NAME Urilda J. Todd
BIRTHPLACE Grantsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 528 74 0602

17. INFORMANT'S OWN SIGNATURE X Dara D. Yates ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of Corpus uteri — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) & abdominal metastasis — 2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

1820

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ____, 19 68, to Sept, 19 69, that I last saw the deceased alive on June, 19 69, and that death occurred at 9:25P m., from the causes and on the date stated above.

23a. SIGNATURE Lenard P. Kearbuen 45 (Degree or title)

23b. ADDRESS

23c. DATE SIGNED 9-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Sept. 16, 1969

24c. NAME OF CEMETERY OR CREMATORY Oakley Cemetery

24d. LOCATION (City, town, or county) Oakley, Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 13, 1969

REGISTRAR'S SIGNATURE Jean A Beatty

25. EMBALMER Glenn W Beatty

LICENSE NO. E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4236
Local Reg. No. 13
Reg. Dist. No. 340 341

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 23 SEP 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
Bureau of Vital Statistics
321
LENGTH OF STAY (in this place) 3 1/2 Wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gem 230
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Rt. 3 Box 415

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Roy	Alvia	Bowman	Sept. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	July 8, 1898	71	2	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 24	furniture	Beaver City, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Martan Van Bowman	Illinois	Ida Mae Mathews	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-09-6358A	Roy A. Bowman, Jr.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary emphysema — 3 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Emmett, Idaho	9-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial-entombment	9/19/69	Mountain View	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-15-69	[signature]	Glenn W. Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 1 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 4237
Local Reg. No. 15
Reg. Dist. No. 340-341

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Gem 231 — SEP 24 1969
b. CITY OR TOWN (If outside corporate limits write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): 3 1/2 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Walter Knox Memorial Hosp. 085

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Earl	Elmer	Kearns	Sept. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Dec. 10, 1887	81	9 / 25	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farm	Leona, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph N. Kearns	unknown	Ida Victoria Mahoney	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-10-7919	Mabel Kearns	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

188X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of urinary bladder
with metastases

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 6 19[illegible], *to* Sept 15, 1969, *that I last saw the deceased alive on* Sept 15, 1969, *and that death occurred at* 11:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B Jewell M.D. 260	1024 E Locust, Emmett, Ida	9-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 19, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-19-69	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4238
Local Reg. No. 16
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED SEP 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Emmett Valley Nursing 086

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Ella b. (Middle) Genett c. (Last) Schultz

4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Apr. 27, 1879

9. AGE (In years last birthday) 90
IF UNDER 1 YR. Months 4 Days 21
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook and nursing 13

10b. KIND OF BUSINESS OR INDUSTRY ---

11. BIRTHPLACE (State or foreign country) Long Island, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James C. Taylor
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME Olive Tennant
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 520 09 2010A

17. INFORMANT'S OWN SIGNATURE X Mary Mountain
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH 96 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19__, to Sept 18, 19 69, that I last saw the deceased alive on Sept 14, 19 69, and that death occurred at 12:05 a.m., from the causes and on the date stated above.

23a. SIGNATURE Lawrence P. Lawrence MD (Degree or title)

23b. ADDRESS Emmett Idaho

23c. DATE SIGNED 9/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Sept. 20, 1969

24c. NAME OF CEMETERY OR CREMATORY Emmett

24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. 9-20-69

REGISTRAR'S SIGNATURE Jean A Beatty

25. EMBALMER Thurman W Beatty

LICENSE NO. E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 24 1969 Bureau of Vital Statistics

State File No. 4239
Local Reg. No. 17
Reg. Dist. No. 340 341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION: Shady Lane Nursing Home 265

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Williams Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Minnie		Blalock	Sept. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	July 27, 1887	82	1	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Vairview, Virginia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charley Arwood	North Carolina	Ibbie Bloomer	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-58-0672T	X Emory Blalock	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Coronary Occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* February 7 1956 *, to* Sept 19 , 1969 *, that I last saw the deceased alive on* Sept 3 , 1969 *, and that death occurred at* 6:55 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B. Jewell MD.	1024 E. Locust, Emmett, Ida	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 23, 1969	Emmett	~~Emmett~~, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-23-69	Jean W. Beatty	Glenn W. Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filing out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 26 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4240
Local Reg. No. 18
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: GEM 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: PAYETTE 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): 119 East Elm

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Guy	Harrison	Oyler	Sept.	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Widowed	July 23, 1893	76	1	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER 04	FARMING	Wilber, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Grant Oyler	Nebraska	Susan Ferguson	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	--	519-18-5815	Betty Marie Hinton	New Plymouth, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Ca of Lung	?
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, *19*____, *to* _____, *19*____, *that I last saw the deceased alive on* _____, *19*____, *and that death occurred at* 3:25A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD		9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-24-1969	Park View	New Plymouth, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 24, 1969	Jean A Beatty	Keith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 1 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4241
Local Reg. No. 19
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Gem 231 SEP 29 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett Bureau of Vital Stat. c. LENGTH OF STAY (In this place) 4 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 055	d. STREET ADDRESS (If rural, give location) Box 204

3. NAME OF DECEASED (Type or Print) a. (First) Matilda	b. (Middle) Delilah	c. (Last) Roland	4. DATE OF DEATH (Month) (Day) (Year) Sept. 25, 1969	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH August 14, 1894	9. AGE (In years last birthday) 75 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Akron, Nebraska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Preston Eugene Silkett	BIRTHPLACE Mahaska County, Ia.	14. MOTHER'S MAIDEN NAME Ida Minerva Cook	BIRTHPLACE Pilot Grove, Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-26-0388A	17. INFORMANT'S OWN SIGNATURE x Clara Gates	ADDRESS Box 204 Emmett	

4121

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Hypertensive C-V-disease	5 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	CVA	5 hrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 9-25-69, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:50P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 184	23b. ADDRESS	23c. DATE SIGNED 9-26-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Sept. 29, 1969	24c. NAME OF CEMETERY OR CREMATORY Parkview	24d. LOCATION (City, town, or county) (State) New Plymouth, Idaho
DATE REC'D BY LOCAL REG. Sept. 26, 1969	REGISTRAR'S SIGNATURE Jean A. Beatty	25. EMBALMER [signature]	LICENSE NO. E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

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DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4242
Local Reg. No. 3171
Reg. Dist. No. 420

BIRTH NO.

RECEIVED
OCT 7 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Trailer House-1735 S. Main

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 1735 South Main St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Ernest	Walker	September 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Sept. 2, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Night Watchman--Leo Rice Motor		Oriënta, Oklahoma	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert M. Walker	Ireland	Sara Webb	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	----------	511-03-8840	Thompson Chapel Records-Gooding, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

890X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Suffocation — INTERVAL BETWEEN ONSET AND DEATH: 2 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Trailer house fire
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	1735 So. Main St. 28	Gooding, 240	Gooding,	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
9-3-1969 11:500 p.m.		Trailer House burned up.

22. *I hereby certify that I attended the deceased from* 3 Sep 1969 *to* 3 Sep 1969 *that I last saw the deceased alive on* 3 Sep 1969, *and that death occurred at* 11:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard Ellsworth MD 773	Gooding Idaho	8 Sep 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Oct. 1, 1969	Elmwood Cemetery	Gooding,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 1, 1969	Eddie G. Leach	Eddie G. Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JUN 24 1970
SEP 8 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4243
Local Reg. No. 1168
Reg. Dist. No. 420

BIRTH NO.

RECEIVED SEP 15 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 10 Mile b. 4 S.E. of Gooding
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Frank Graves Farm-S. b. of City

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bliss
d. STREET ADDRESS (If rural, give location) P.O. Box 33

3. NAME OF DECEASED (Type or Print) a. (First) Leslie b. (Middle) Hugh c. (Last) Parsons

4. DATE OF DEATH (Month) (Day) (Year) Sept. 8, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH April 7, 1901

9. AGE (In years last birthday) 68
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired--Farming 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Fairfield, Iowa

12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Jesse Parsons
BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Catherine Allerdice
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 518-16-0280

17. INFORMANT'S OWN SIGNATURE Ruth C. Parsons
ADDRESS Bliss, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — 2 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension & Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Sep, 1969, to 8 Sep, 1969, that I last saw the deceased alive on 8 Sep, 1969, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE Richard Ellsworth 583 (Degree or title) coroner

23b. ADDRESS Gooding, Idaho 83330

23c. DATE SIGNED 10 Sep 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-11-1969

24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery

24d. LOCATION (City, town, or county) Hagerman (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 12, 1969

REGISTRAR'S SIGNATURE Eddie Leach

28. EMBALMER Eddie Leach

LICENSE NO. E-511

FIRM NAME Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4244
Local Reg. No. 3169
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gooding 240 SEP 1 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerman-8 East of 3 North
c. LENGTH OF STAY (In this place) Bureau of Vital
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Stockton Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bliss
d. STREET ADDRESS (If rural, give location) Star Route

3. NAME OF DECEASED (Type or Print) a. (First) Jane b. (Middle) Lucille c. (Last) Pruett

4. DATE OF DEATH (Month) Sept. (Day) 8, (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH July 19, 1951

9. AGE (In years last birthday) 18 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03

10b. KIND OF BUSINESS OR INDUSTRY Education

11. BIRTHPLACE (State or foreign country) Gooding, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ralph Pruett BIRTHPLACE Oregon

14. MOTHER'S MAIDEN NAME Edith Harder BIRTHPLACE Glennsferry, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -------

16. SOCIAL SECURITY NO. 519-62-0190

17. INFORMANT'S OWN SIGNATURE X Ralph E Pruett ADDRESS Hagerman, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

955X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Exsanguination — INTERVAL BETWEEN ONSET AND DEATH: 3 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) gunshot wound —
DUE TO (c) suicide —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) 2 Suicide

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Stockton Home 31

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Hagerman Gooding, 240 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 8, 1969 6:45 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Self inflicted gun shot wound

22. I hereby certify that I attended the deceased from 8 Sep, 19 69, to 8 Sep, 19 69, that I last saw the deceased alive on 8 Sep, 19 69, and that death occurred at 6:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE Richard E Thurston 583 (Degree or title) Coroner

23b. ADDRESS Gooding, Idaho

23c. DATE SIGNED 10 Sep 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 13, 1969

24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery

24d. LOCATION (City, town, or county) Gooding, (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 12, 1969

REGISTRAR'S SIGNATURE Eddie D. Leach

26. EMBALMER Eddie D. Leach

LICENSE NO. E-511

FIRM NAME Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4245
Local Reg. No. 3172
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Gooding 240 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman — c. LENGTH OF STAY (In this place): 4 Years — d. FULL NAME OF HOSPITAL OR INSTITUTION: Rural——R.F.D. # 1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE: Idaho — b. COUNTY: Gooding 240 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman — d. STREET ADDRESS (If rural, give location): R.F.D. # 1

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HENRY	RAYMOND	TAYLOR	Sept. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 19, 1910	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Monett, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Nathan Taylor	Missouri	Sarah Allen	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	512-22-9245	Mrs. H. R. Taylor	RED # 1 Hagerman, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — 955X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gunshot wound of chest — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
2 Suicide	Home 31	Hagerman	Gooding 240	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Sept. 18, 1969 a.m.		Gunshot Wound To The Chest

22. I hereby certify that I attended the deceased from Investigation Only, to ____, 19__, that I last saw the deceased alive on 18 Sep, 1969, and that death occurred at 735 A m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
533 4 (Degree or title) Coroner	Gooding Idaho	10-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/22/69	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
October 1, 1969	Eddie Enfield	George Farmer	E-480

Federal Security Agency
United States Public Health Service FORM DH-6302

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 11 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4246
Local Reg. No. 3173
Reg. Dist. No. 420

RECEIVED
Bureau of Vital Statistics
OCT 7 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN Wendell
LENGTH OF STAY (in this place) 22 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION 3½ W. 1 So. ½ W. of Wendell 202

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gooding 240
c. CITY OR TOWN Rural Wendell
d. STREET ADDRESS (If rural, give location) 3½ W. 1 So. ½ W. of Wendell

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ENOS	EDGAR	ANDREWS	Sept. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 8, 1904	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 24	Farm	Parson, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Guy C. Andrews	Ohio	Ida Myrtle Shoemaker	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	518-42-5846	Lois E. Andrews	Wendell, Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction, recurrent — INTERVAL BETWEEN ONSET AND DEATH: 1-2 mins.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary atherosclerosis

DUE TO (c) Pulmonary emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bilateral inguinal hernia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1/12/50, 19 50, *to* 9/27/, 19 69 *that I last saw the deceased alive on* 6/17/, 19 69, *and that death occurred at* 10:15 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold G. Holsinger 240 M.D.	Wendell, Idaho	9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 1, 1969	Wendell Cemetery	Wendell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 3, 1969	Eddy Leach	Joe B. Leeper Joe B. Leeper	E-530

FIRM NAME: Leeper Mortuary Wendell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: OCT 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4247
Local Reg. No. 37
Reg. Dist. No. 240

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 252
b. CITY OR TOWN Grangeville
LENGTH OF STAY (in this place) 2
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Grangeville Gen. Hosp 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN Kooskia
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Kenneth
b. (Middle) Frank
c. (Last) McKenzie

4. DATE OF DEATH (Month) Sept (Day) 1 (Year) 69

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 7 1878
9. AGE (In years last birthday) 91
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith
10b. KIND OF BUSINESS OR INDUSTRY Own Shop
11. BIRTHPLACE (State or foreign country) Lucas Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Alexander McKenzie
BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Katherine Dick
BIRTHPLACE Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16. SOCIAL SECURITY NO. 518-36-4583
17. INFORMANT'S OWN SIGNATURE Thelma B. McKenzie
ADDRESS. Kooskia Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia
INTERVAL BETWEEN ONSET AND DEATH Few days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis & Uremia.

485X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-26, 1969, *to* 1 Sept, 1969, *that I last saw the deceased alive on* 1 Sept, 1969, *and that death occurred at* 1:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Donald Altman 487 (Degree or title) M.D.
23b. ADDRESS Grangeville Idaho
23c. DATE SIGNED 6 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 5 1969
24c. NAME OF CEMETERY OR CREMATORY Pine Grove
24d. LOCATION (City, town, or county) (State) Kooskia Ida., Idaho

DATE REC'D BY LOCAL REG. Sept. 9 1969
REGISTRAR'S SIGNATURE Irma Cone
25. EMBALMER Robert Hamer
LICENSE NO. E433
FIRM NAME: Irenary Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 2 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 1 6 1992

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4248
Local Reg. No. 33
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 SEP 1 1 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dixie
c. LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home on Dixie Summit 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dixie
d. STREET ADDRESS (If rural, give location): Elk City Red River Rural Rt

3. NAME OF DECEASED (Type or Print)
a. (First): CLIFFORD
b. (Middle): EARL
c. (Last): FREAD

4. DATE OF DEATH (Month) (Day) (Year): Sept 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 27, 1908
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minner Logger 07
10b. KIND OF BUSINESS OR INDUSTRY: Minning & Logging
11. BIRTHPLACE (State or foreign country): Elgin Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clyde O Fread — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Bessie Bridge — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 564 28 9657
17. INFORMANT'S OWN SIGNATURE: Clara B Fread — ADDRESS: Dixie, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7824

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apparent Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 583 4
23b. ADDRESS: IDAHO COUNTY CORONER
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept. 6, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433
FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4249
Local Reg. No. 58
Reg. Dist. No. 240

BIRTH NO.

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Idaho 25D
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hosp. 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 25D
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): East 402 South 1st

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRED	SHAW	BROWN	Sept 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 15, 1887	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Business Man 22	Auto Agency Owner	Punxsutawney, Penn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank E Brown	Unknown	Annie	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 03 5436 A	Mrs Fred Brown	Grangeville, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Emphysema

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* about 1963 *to* 4 Sept 1969, *that I last saw the deceased alive on* 4 Sept 1969, *and that death occurred at* 8:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Coltman 487 M.D.	Grangeville, Idaho	5 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/6/69	Prairieview	Grangeville, Idaho

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 10 1969	Irma Cone	Robert R Hansen	E 433

FIRM NAME: hansen funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 14 1963

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 27 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4250
Local Reg. No. 57
Reg. Dist. No. 240

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 250 Idaho — SEP 1 1 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hosp 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California
b. COUNTY: 055 Santa Clara 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): San Jose
d. STREET ADDRESS (If rural, give location): 2744 Lansford

3. NAME OF DECEASED (Type or Print): a. (First) PAULINE b. (Middle) ROCKWELL c. (Last) SWERTELLE

4. DATE OF DEATH (Month) (Day) (Year): Sept 5, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 22, 1913

9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Dickenson North Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: N.L. Rockwell — BIRTHPLACE: Mass.

14. MOTHER'S MAIDEN NAME: Pauline Valden — BIRTHPLACE: Mass

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Yes

17. INFORMANT'S OWN SIGNATURE: Pauline Swertelle — ADDRESS: San Jose Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intra Cerebellar hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary fibrosis Bronchial illitis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 Sept, 1969, *to* 5 Sept, 1969, *that I last saw the deceased alive on* 5 Sept, 1969, *and that death occurred at* 12:40 PM *from the causes and on the date stated above.*

23a. SIGNATURE: Donald Saltzman 487 (Degree or title): M.D — **23b. ADDRESS**: Grangeville, Ida. — **23c. DATE SIGNED**: 6 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): B Transportation — **24b. DATE**: 9/6/69. — **24c. NAME OF CEMETERY OR CREMATORY**: Lakewood Cemetery — **24d. LOCATION** (City, town, or county) (State): Minneapolis, Minnesota

DATE REC'D BY LOCAL REG.: Sept. 8 1969 — **REGISTRAR'S SIGNATURE**: Irma Cone

25. EMBALMER: Robert R Hansen — Robert R Hansen — **LICENSE NO.**: E 423

FIRM NAME: Hansen funeral home

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 16 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. OCT 24 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4251
Local Reg. No. 240
Reg. Dist. No. 60

Certificate of Death

RECEIVED
OCT 3 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (In this place): 6 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho County Nursing Home 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Tolo Lake Area

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): MICHAEL
c. (Last): DAUBER

4. DATE OF DEATH (Month) (Day) (Year): September 10, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: December 21, 1873
9. AGE (In years last birthday): 95 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael Dauber — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Barbitte Kamerr — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519 56 6391 T
17. INFORMANT'S OWN SIGNATURE: Mrs Thelma [illegible] — ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infirmities of age — INTERVAL BETWEEN ONSET AND DEATH: indef.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1960, *to* Sept 10, 1969, *that I last saw the deceased alive on* Sept 2, 1969, *and that death occurred at* 5 40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Marion MD 373
23b. ADDRESS: Grangeville, Id
23c. DATE SIGNED: 9/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: p/12/69
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept 30 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4252
Local Reg. No. 18
Reg. Dist. No. 242

RECEIVED OCT 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (in this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reubens
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Annie	V.	Webb	Sept	11	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	Oct 1 1886	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	General Merchandis	Store Bronaugh, Missouri	U S

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George A. Shaul		Elizabeth Hartman	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	531 16 3684 D	Claude Webb	Culdesac, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Acute myocardial Infarction	Minutes
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	ASHD	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Acute Cholecystitis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August 30 19 69, *to* Sept. 11, 19 69, *that I last saw the deceased alive on* Sept. 11, 19 69, *and that death occurred at* 2:40 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard E Orr M D	Cottonwood, Idaho	Sept. 16, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 13, 1969	Reubens	Reubens, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22, 1969	Elizabeth A. Uhlorn	Clifford Uhlorn	E 127

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

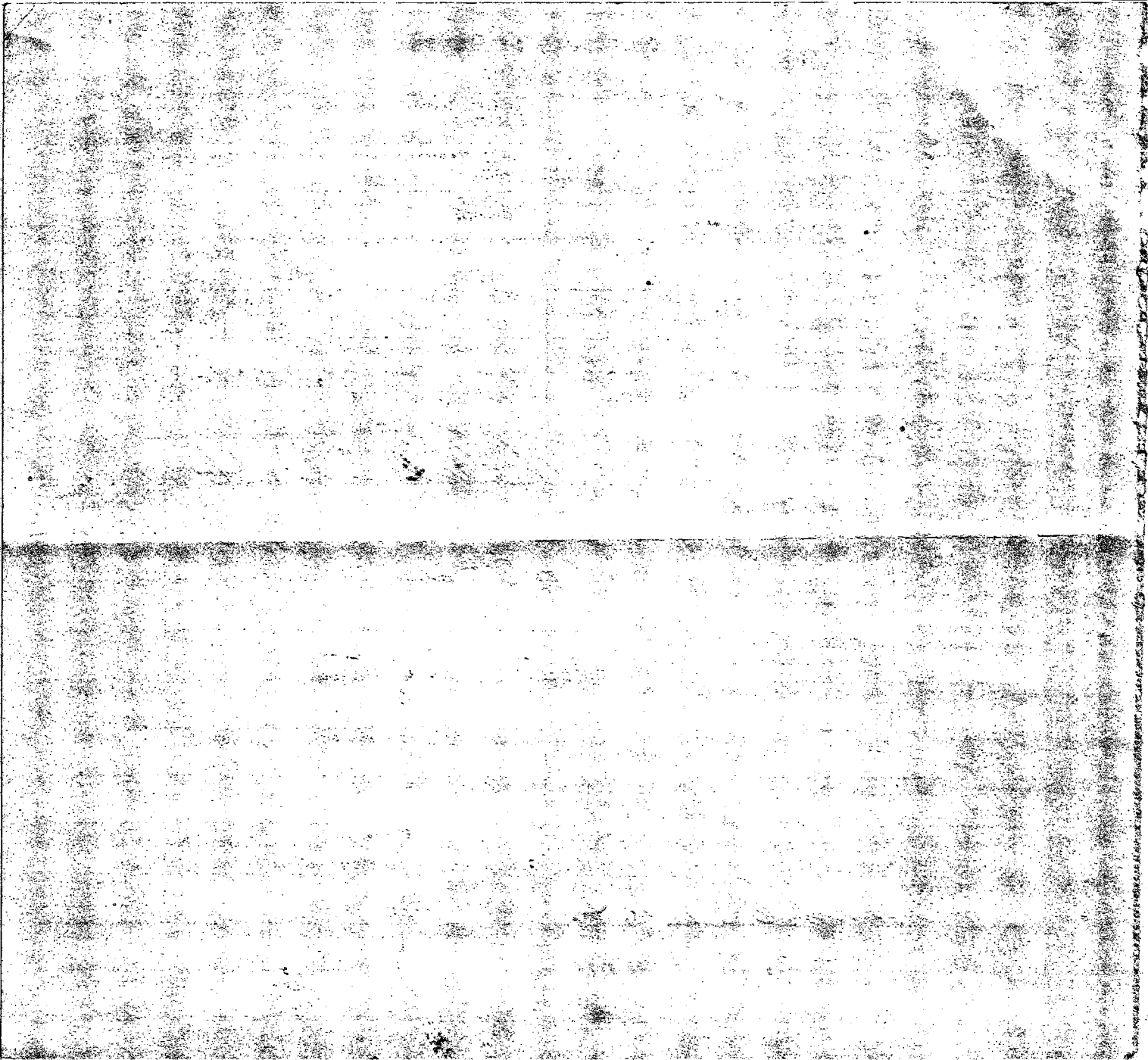

State File No. 4253
Local Reg. No. 240
Reg. Dist. No. 62

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 OCT 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township or place): Grangeville
c. LENGTH OF STAY (If outside place): 28 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Hill Manor 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Stites
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Arthur
b. (Middle): Edwin
c. (Last): Lamb

4. DATE OF DEATH (Month) (Day) (Year): Sept. 13, 1969

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 15, 1891
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Land
11. BIRTHPLACE (State or foreign country): Hunters Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Henry Lamb — BIRTHPLACE: Calif.
14. MOTHER'S MAIDEN NAME: Talitha E Phar — BIRTHPLACE: The Dalles, Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-40-8580
17. INFORMANT'S OWN SIGNATURE: Henry Lamb — ADDRESS: 1332 Burrell Lewiston

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Large Bowel obstruction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — Probable Cancer of Colon

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Severe C.V.A with Marked Organic Brain — 2 yrs

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Syndrome
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* Sept 13, 1969 *that I last saw the deceased alive on* Sept 13 1969 *and that death occurred at* 8:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Mannion MD 373
23b. ADDRESS: Grangeville, Id
23c. DATE SIGNED: Sept 19, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 16 1969
24c. NAME OF CEMETERY OR CREMATORY: Pine Grove Cem.
24d. LOCATION (City, town, or county) (State): Kooskia Ida. Idaho.

DATE REC'D BY LOCAL REG.: Sept. 30, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — LICENSE NO.: E433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Trenary Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED OCT 3 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4254
Local Reg. No. 240
Reg. Dist. No. 61

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkhill Nursing Home 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): Orofino, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): FRANK
b. (Middle): LEE
c. (Last): EDWARDS

4. DATE OF DEATH (Month) (Day) (Year): Sept 15, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: April 11, 1904
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder-Blacksmith 21
10b. KIND OF BUSINESS OR INDUSTRY: Various
11. BIRTHPLACE (State or foreign country): Grangeville, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Christopher C. Edwards — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Mary Fields XXXXXXX — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 01 1845
17. INFORMANT'S OWN SIGNATURE: William Edwards
ADDRESS: Grangeville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*
(a) Bronchogenic Carcinoma of left lung with metastasis, multiple, to Brain, Trachea, mediastinum, and adrenals
DUE TO (b)
DUE TO (c)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1, 1969, *to* Sept 15, 1969, *that I last saw the deceased alive on* Sept 14, 1969, *and that death occurred at* 1:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Mannion 373 MD
23b. ADDRESS: Grangeville, Id
23c. DATE SIGNED: Sept 19, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/18/69
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept. 30, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433
FIRM NAME: Hansen funeral home

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4255
Local Reg. No. 240
Reg. Dist. No. 63

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Idaho 253 — OCT 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY IN (this place): 4 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital 372

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nezperce
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Cynthia
b. (Middle): Jane
c. (Last): Thomas

4. DATE OF DEATH: (Month) Sept (Day) 18 (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Feb 12 1889

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lyon County, Iowa

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Daniel Hoover — BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Sarah Jane Steele — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 36 4740 B

17. INFORMANT'S OWN SIGNATURE: Cyden Thomas — ADDRESS: Nezperce, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1990 Pleural Effusion of unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) origin, Probable
DUE TO (c) Metastatic Cancer

INTERVAL BETWEEN ONSET AND DEATH: 1 month

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* August, 1969, *to* Sept 18, 1969, *that I last saw the deceased alive on* Sept 18, 1969, *and that death occurred at* 6:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wm Mannion 373 MD (Degree or title)
23b. ADDRESS: Grangeville, Id
23c. DATE SIGNED: Sept 18, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Community
24d. LOCATION (City, town, or county) (State): Nezperce, Lewis Idaho

DATE REC'D BY LOCAL REG.: Sept 30 1969
REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: Elliott Uhlorn
LICENSE NO.: E 421

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4256
Local Reg. No. 240
Reg. Dist. No. 64

BIRTH NO.

OCT 3 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 48 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 614 South 1st Street

3. NAME OF DECEASED (Type or Print): a. (First) LYNZA; b. (Middle) J; c. (Last) EARP

4. DATE OF DEATH (Month) (Day) (Year): September 19, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: September 2 1890

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Rancher

11. BIRTHPLACE (State or foreign country): Grangeville, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph G Earp — BIRTHPLACE: Springfield, Missouri

14. MOTHER'S MAIDEN NAME: Melinda Vellie Seay — BIRTHPLACE: Benton County Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 516 40 8731A

17. INFORMANT'S OWN SIGNATURE: Marjorie L. Wren — ADDRESS: Grangeville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

185X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Terminal Bronchopneumia 1 week

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 1960, *to* Sept 19, 1969, *that I last saw the deceased alive on* Sept 19 1969, *and that death occurred at* 6:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Morrison MD 3273

23b. ADDRESS: Grangeville, Id

23c. DATE SIGNED: 9/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/22/69

24c. NAME OF CEMETERY OR CREMATORY: Prairieview

24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept 30, 1969

REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: Robert R Hansen — Robert R Hansen

LICENSE NO.: E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 3 1969

NOV 2 7 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4257
Local Reg. No. 20
Reg. Dist. No. 242

BIRTH NO.

1. PLACE OF DEATH — 250
a. COUNTY: Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville, Idaho
d. STREET ADDRESS (If rural, give location): 604 East Elm Street

3. NAME OF DECEASED (Type or Print): a. (First) MOLLY b. (Middle) MARIE c. (Last) CHADWICK

4. DATE OF DEATH (Month) (Day) (Year): Sept 30, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept 15, 1954
9. AGE (In years last birthday): 15 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: High School
11. BIRTHPLACE (State or foreign country): Enterprise, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wayne Chadwick — BIRTHPLACE: Plavna, Montana
14. MOTHER'S MAIDEN NAME: Marjorie Wilson — BIRTHPLACE: Imnaha, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Wayne Chadwick — ADDRESS: Grangeville, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 996X Contusion brain severe with — INTERVAL BETWEEN ONSET AND DEATH: 7 & hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) decerebrate rigidity
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Fairgrounds 25
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Nezperce — Lewis 310 — Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 27, 1969 p m. 4:15
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: thrown from horse. Horse fell on her.

22. *I hereby certify that I attended the deceased from* Sept. 27, 1969, *to* Sept. 30, 1969, *that I last saw the deceased alive on* Sept. 30, 1969, *and that death occurred at* 11:59P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 398 Richard E Orr M.D.
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: Oct.3,1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: October 4, 1969
REGISTRAR'S SIGNATURE: Elizabeth H. Uhlorn
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433
FIRM NAME: ~~Hansen funeral home~~

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4258
Local Reg. No. 8
Reg. Dist. No. 640

BIRTH NO.

RECEIVED
OCT 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
c. LENGTH OF STAY (In this place): 20 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rte. #2 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 26
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): Rte. #2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	AUDIE	CLINTON	MORRIS	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Feb. 15, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Well driller 21	well drilling	Little Rock, Arkansas.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Tom Morris	no record	Josephine	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-18-2921-A	Mrs. U.C. Morris	Rigby, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Heart Disease — 11 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	None performed -	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 30 Sept. 1954 *to* 1 Sept. 1969, *that I last saw the deceased alive on* 1 Sept. 1969, *and that death occurred at* 1:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Asael Hall 522	M.D.	Rigby, Idaho.	2 Sept. 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 4, 1969	Rigby Pioneer	Rigby Jefferson Idaho

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 2 1969	Mrs A B Eckersell	Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4259
Local Reg. No. 9
Reg. Dist. No. 640

BIRTH NO.

RECEIVED
OCT 1 1969
Bureau of Vital Statistics

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Roberts
c. LENGTH OF STAY (in this place): inst.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 mi. So. of Roberts 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Terreton
d. STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print): a. (First) DERAL b. (Middle) JOE c. (Last) HAYCOCK

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: July 4, 1947

9. AGE (In years last birthday): 22
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Parts Man 21

10b. KIND OF BUSINESS OR INDUSTRY: Implement

11. BIRTHPLACE (State or foreign country): Wendell, IDAHO.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Deral Joseph Haycock
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: June Albertson
BIRTHPLACE: Jackson, Mont.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Viet Nam 7

16. SOCIAL SECURITY NO.: 519-56-4422

17. INFORMANT'S OWN SIGNATURE: Deral J Haycock
ADDRESS: Terreton, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive skull fracture — INTERVAL BETWEEN ONSET AND DEATH: inst.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Automobile accident.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 04
21c. (CITY, TOWN, OR TOWNSHIP) 260 **(COUNTY)** **(STATE)**: Roberts Jefferson Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 21, 1969 6:15 A m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Struck pole with automobile.

22. *I hereby certify that I attended the deceased from* ~~XXXX

DUTIES:

OCT 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 8 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. MAR 1 1 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 4260
Local Reg. No. 1243
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome SEP 10 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Benedicts Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome, 83338
d. STREET ADDRESS (If rural, give location) 426 10th Ave. E.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HANS	A.	THAEMERT	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 26, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Sylvan Grove, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	518-14-3868	[signature]	Twin [illegible], Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema severe — 8 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9/30, 1968 to 9/1, 1969, that I last saw the deceased alive on 9/1, 1969, and that death occurred at 4:10 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. E. Sloat MD	Jerome Idaho	9/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept., 4, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 8, 1969	Lowell M. Scherer	Edgar J. Robertson	E-507

FIRM NAME: White Mortuary - Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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Certificate of Death

State File No. 4261
Local Reg. No. 1244
Reg. Dist. No. 440

BIRTH NO.

RECEIVED SEP 16 1969

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Jerome

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome

c. LENGTH OF STAY (in this place): Bureau of Vital Statistics

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Lincoln

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richfield

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CECILE	D.	GRENFELL	Sept. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed	Feb. 23, 1883	86	6	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Teacher 12	Teaching	Eaton Rapids, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joel J. Hayward	Michigan	Frances Mann	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	None	X Irene Rubenicki	Richfield, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death Pulmonary emphysema & chr. bronchitis — Many years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept. 8, 1969, *to* Sept. 10, 1969, *that I last saw the deceased alive on* Sept. 10, 1969, *and that death occurred at* 8:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jon D. Wilmoth, M.D.	214 East Main St. Jerome Idaho	Sept. 12, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-15-1969	Richfield Cemetery	Richfield, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-15-69	M. Lone Overfield acting R.	Frances M. Bergin	E-163

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4262
Local Reg. No. 1245
Reg. Dist. No. 440

BIRTH NO. SEP 22 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 83338 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 094

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 83338
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 213 East Ave. "D"

3. NAME OF DECEASED (Type or Print)
a. (First) Ida
b. (Middle) A.
c. (Last) Caldwell

4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH March 16, 1891
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Madison Co., Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Christoph Von der Ohe — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Amelia — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 26 4085
17. INFORMANT'S OWN SIGNATURE X Mrs Myra LeClair — ADDRESS Jerome, I

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 days.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Subendocardial myocardial infarction 4 days; Severe congestive heart failure Severe years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 23, 1968, *to* September 17, 1969, *that I last saw the deceased alive on* September 12, 1969, *and that death occurred at* 10:55 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Jon D. Wilmoth, M.D. 770
23b. ADDRESS 216 East Main, Jerome, Idaho 83338
23c. DATE SIGNED Sept 16, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery
24d. LOCATION (City, town, or county) (State) Madison, Nebraska

DATE REC'D BY LOCAL REG. Sept. 19, 1969
REGISTRAR'S SIGNATURE M. Gene Overfield Rn Acting
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hove Funeral Chapel

FEB 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 16 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 25 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4263
Local Reg. No. 1247
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 270 Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place) 35 yrs +
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Benedicts Hospital 044

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) Jerome, Idaho 83338

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	George	Gibb	Bird	September 16.1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married	Oct. 14 1906	62	11 / 2	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Knight Watchman 06
10b. KIND OF BUSINESS OR INDUSTRY IDA-GEM DAIRY
11. BIRTHPLACE (State or foreign country) Teton City Idaho
12. CITIZEN OF WHAT COUNTRY? U Sa

13. FATHER'S NAME Charles Henry Bird, BIRTHPLACE Medon Utah
14. MOTHER'S MAIDEN NAME Agnes Gibb. BIRTHPLACE Brighton Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-05-3403
17. INFORMANT'S OWN SIGNATURE x George Gibb Bird ADDRESS Wendell Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

485 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia, st. Lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary emphysema & chr. bronchitis — years; Bleeding duodenal ulcer — 2 years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from September 27 1969, to September 16, 1969, that I last saw the deceased alive on September 16, 1969, and that death occurred at 3:35P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jon D. Wilcoth, M.D. 770	216 E. Main; Jerome, Idaho	Sept. 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/19/1969	Jerome Cemetery	Jerome Idaho 83339

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Sept. 24 1969	M. Gene Overfield	J R Wiley	Jerome Idaho 83338

Wiley Funeral Home 258 - License No

Federal Security Agency
United States Public Health Service
Form DPH-48021 (rev 4)

OCT 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of J. P. Wiley Lic. No. E-25-E at Jerome Idaho on 9/16/69

ADDITIONAL REMARKS by Physician

Certificate of Death

STATE OF IDAHO

State File No. 4264
Local Reg. No. 1246
Reg. Dist. No. 440

BIRTH NO.

RECEIVED SEP 24 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Nursing Home 351

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 801 South Davis

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CATHERINE	SMITH	BROWN	Sept. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Nov. 5, 1869	99				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Groff, Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Lydecker	Germany	Margaret ---	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 60 8830	X Irene Simpson	Jerome, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Decompensation — 10yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 16, 1949 *to* Sept 14, 1969, *that I last saw the deceased alive on* Sept 18, 1969, *and that death occurred at* 11:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. Howe 476	M.D.	Jerome Ida	9/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 22, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 23 1969	Irene Swafford	W. L. Howe	E-431

Federal Security Agency
United States Public Health Service

Form DH-63021 Acute

FIRM NAME: Hove Funeral Chapel

OCT 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4265
Local Reg. No. 1249
Reg. Dist. No. 440

RECEIVED OCT 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place): 1½ years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Nursing Home 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): Lincoln North

3. NAME OF DECEASED (Type or Print): a. (First) REBECCA b. (Middle) LAMAR c. (Last) BLACKBURN

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 20, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 5, 1882

9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Provo, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Isaac Roberts
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Susan Alexander
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-60-7768-7

17. INFORMANT'S OWN SIGNATURE: George Blackburn
ADDRESS: Wendell, Ida. 83355

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary atherosclerosis — 4 yrs.
DUE TO (c): Generalized arteriosclerosis — 8 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic cystitis — 6 mo.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 31, 19 66, *to* Sept. 20, 19 69, *that I last saw the deceased alive on* 9-19, 1969, *and that death occurred at* 6:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold G. Holsinger M.D.

23b. ADDRESS: Wendell, Ida.

23c. DATE SIGNED: 9/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 24, 1969

24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept 29 1969

REGISTRAR'S SIGNATURE: M. Gene Overfield RN

25. EMBALMER: Joe B. Leeper Joe B Leeper

LICENSE NO.: E-530

FIRM NAME: Leeper Mortuary Wendell Idaho 83355

Federal Security Agency
United States Public Health Service

Form DH-630216 (5-67)

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4266
Local Reg. No. 1248
Reg. Dist. No. 440

Certificate of Death

RECEIVED
SEP 25 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 328 East Ave F

3. NAME OF DECEASED (Type or Print)
a. (First): Richard
b. (Middle): K
c. (Last): Tracy

4. DATE OF DEATH (Month) (Day) (Year): September 22 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 23. 1898
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months 3, Days 29 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Sun City Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Not Known — BIRTHPLACE: Not Known
14. MOTHER'S MAIDEN NAME: Not Known — BIRTHPLACE: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 540-18-7350
17. INFORMANT'S OWN SIGNATURE: Lillian I. Tracy — ADDRESS: Jerome Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — 10 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/22, 1969, *to* 9/22, 1969, *that I last saw the deceased alive on* ~~[illegible]~~, *and that death occurred at* 3:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. E. Moas 476 (Degree or title) MD.
23b. ADDRESS: Jerome Ida
23c. DATE SIGNED: 9/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/25/69
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome Idaho 83338

DATE REC'D BY LOCAL REG.: Sept 24 1969
REGISTRAR'S SIGNATURE: M. Gene Overfield Ass't
25. FUNERAL DIRECTOR: J R Wiley — ADDRESS: Jerome Idaho 83338
Wiley Funeral Home #258

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

FEB 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of J R Wiley Lic. No. E 205 at Jerome Idaho on 9/22/69

ADDITIONAL REMARKS by Physician

Certificate of Death

STATE OF IDAHO

State File No. 4267
Local Reg. No. 12 503
Reg. Dist. No. 440

BIRTH NO.

RECEIVED
OCT 3 1969
Bureau of Vital

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 4 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): Route # 4 East of City

3. NAME OF DECEASED (Type or Print): a. (First) NANCY; b. (Middle) GWEN; c. (Last) WOODLAND

4. DATE OF DEATH (Month) (Day) (Year): Sept. 24, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: July 4, 1965

9. AGE (In years last birthday): 4
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 00

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Rupert, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Gerwin Ernest Woodland
BIRTHPLACE: Pocatello, Ida.

14. MOTHER'S MAIDEN NAME: Evelyn Peterson
BIRTHPLACE: Idaho Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Nancy Woodland
ADDRESS: Jerome, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2070

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Leukemia of childhood — INTERVAL BETWEEN ONSET AND DEATH: 2½ years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour):

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10/25, 1965, *to* 9/24, 1969, *that I last saw the deceased alive on* 9/23, 1969, *and that death occurred at* 12:15a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): F. M. Wright, MD 576

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 9/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/26/1969

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: Sept. 30 1969

REGISTRAR'S SIGNATURE: M. Kaye Overfield Reg

25. EMBALMER: Edgar Robertson
LICENSE NO.: E-507

FIRM NAME: White Mortuary Twin Falls, Id

Federal Security Agency
United States Public Health Service
Form DH-630/1

DUTIES:

OCT 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4268
Local Reg. No. 1251
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hosp. D.O.A. 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 610 So. Fillmore

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): FREDRICK
c. (Last): HAEFFNER

4. DATE OF DEATH (Month) (Day) (Year): Sept. 25, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 27, 1892
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Buffalo, New York
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fredrick Haeffner — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Marie ---- — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 506 07 8995
17. INFORMANT'S OWN SIGNATURE: X Mrs Dora Haeffner — ADDRESS: Jerome, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: 1-2 min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Dead upon arrival @ Hospt. O.P.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Prior to death Not seen, 19__, *for this illness, that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 9:00P *m. from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 336 Reuben C. Matson MD
23b. ADDRESS: Jerome Ida
23c. DATE SIGNED: 9-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Wyuka Cemetery
24d. LOCATION (City, town, or county) (State): Lincoln, Nebraska

DATE REC'D BY LOCAL REG.: Oct 1 1969
REGISTRAR'S SIGNATURE: M. Gene Overfield RN
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service

Form DH-63021 Wash

FIRM NAME: Hove Funeral Chapel

DUTIES:

OCT 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4269
Local Reg. No. 1252
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 049

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 612 East Ave. "B"

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH
b. (Middle) DWIGHT
c. (Last) McGILL

4. DATE OF DEATH (Month) (Day) (Year) Sept. 26, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 24, 1897
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman 22
10b. KIND OF BUSINESS OR INDUSTRY Retail sales
11. BIRTHPLACE (State or foreign country) Cambridge, Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William R. McGill — BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Mary --- — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 40 1446
17. INFORMANT'S OWN SIGNATURE X Mrs Kathryn L. McGill — ADDRESS Jerome, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — 10 days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Antral Gastric Ulcer surgery ~~Carcinoma of Colon~~ 22 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/20, 1969, *to* 9/26, 1969, *that I last saw the deceased alive on* 9/26, 1969, *and that death occurred at* 8:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE 476 J. E. Hove (Degree or title) MD.
23b. ADDRESS Jerome Ida
23c. DATE SIGNED 9/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 29, 1969
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. Oct 1 1969
REGISTRAR'S SIGNATURE M. Gene Overfield, RN Asst
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hove Funeral Chapel

DUTIES:

OCT 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4270
Local Reg. No. 1253
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 OCT 8 1969
b. CITY OR TOWN Jerome 83338 (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 1 Hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedicts Hospital 044

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
d. STREET ADDRESS (If rural, give location) North Main St.

3. NAME OF DECEASED (Type or Print)
a. (First) ETHEL
b. (Middle) BELDEN
c. (Last) INLOW

4. DATE OF DEATH (Month) (Day) (Year) September 29, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 6-12-1888

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Omaha, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Palmer Belden
BIRTHPLACE New York

14. MOTHER'S MAIDEN NAME Cora Stone
BIRTHPLACE UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 519-01-4438-D

17. INFORMANT'S OWN SIGNATURE Evelyn M. Gibson
ADDRESS Gooding

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4270

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic congestive heart failure
DUE TO (c) Acute gastroenteritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Recent pneumonitis Deafness

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/51, 19 43, *to* 9/29/, 1969, *that I last saw the deceased alive on* 9/29/69, 19___, *and that death occurred at* 1:05 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 240 Harold G. Holsinger MD

23b. ADDRESS Wendell, Ida

23c. DATE SIGNED 9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 2, 1969

24c. NAME OF CEMETERY OR CREMATORY Wendell Cemetery

24d. LOCATION (City, town, or county) (State) Wendell, Idaho

DATE REC'D BY LOCAL REG. Oct 6 1969

REGISTRAR'S SIGNATURE M. Gene Overfield, RN

25. EMBALMER Joe B. Leeper Joe B Leeper

LICENSE NO. E-530

FIRM NAME: Leeper Mortuary Wendell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021 Asst

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED SEP 8 1969 Bureau of Vital Statistics

State File No. 4271
Local Reg. No. 256
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 281 Kootenai	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene; c. LENGTH OF STAY (In this place) 18 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) Axel	b. (Middle)	c. (Last) Lindquist	4. DATE OF DEATH (Month) (Day) (Year) Sept. 1, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept.25,1880	9. AGE (In years last birthday) 88 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logger 17	10b. KIND OF BUSINESS OR INDUSTRY Lumber Worker	11. BIRTHPLACE (State or foreign country) Sweden	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unobtainable	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Unobtainable	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 531-24-6618	17. INFORMANT'S OWN SIGNATURE Albert Nelson (SE)	ADDRESS Hauser Lake, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	C.V.A. c̄ rt. hemiplegia	17 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertension	Chronic.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/13/69, 19___, *to* 9/1/69, 19___, *that I last saw the deceased alive on* 9/1/69, 19___, *and that death occurred at* 11:30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title) Lynn C. Fredrikson MD	23b. ADDRESS Coeur d'Alene Idaho	23c. DATE SIGNED 9/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2	24b. DATE Sept.4,1969	24c. NAME OF CEMETERY OR CREMATORY Moon Crematory	24d. LOCATION (City, town, or county) (State) Sandpoint, Idaho
DATE REC'D BY LOCAL REG. Sept 4, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics
SEP 17 1969

State File No. 4272
Local Reg. No. 259
Reg. Dist. No. 126

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene,

LENGTH OF STAY (In this place) 8 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Ida ho b. COUNTY Kootenai 250

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Route #2 Coeur d' Alene

d. STREET ADDRESS (If rural, give location) Rt. #2 Box 126

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARIETTA		CHANDLER	Sept. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. Last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Cau.	Widowed	2/6/1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Baker	New York	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	504-01-6192D	Fred Chandler	Hayden Lake, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1712 Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Fibrosarcoma arm — years

DUE TO (c) Pneumonia —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3-20, 1968, *to* 9-3, 1969, *that I last saw the deceased alive on* 9-3, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. H. [illegible] MD	Hayden Lake, Idaho	9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/8/69	Restlawn Mem. Park	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 8, 1969	Lorraine K. Brush	Frank Houde	E-521

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 26 1969
JUN 6 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4273
Local Reg. No. 273
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280
SEP 2 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bayview
c. LENGTH OF STAY IN THIS PLACE
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ODD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Spokane 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) W. 1121 Francis Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Helen	Adele	Thorpe	September 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Sept. 25, 1920	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 0/	At Home	Creston, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roy Anyan		Minnie Watson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Glen D. Thorpe	W. 1121 Francis Spokane, Wash.

4273

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Imm.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. + Coroner	Coeur d'Alene, Idaho	9-16-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/3/69	Greenwood Memorial Terrace	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 18, 1969	Lorraine K. Brush	Henry Resleff	QL 464 WN

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hazen & Jaeger Funeral Homes, Inc.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4274
Local Reg. No. 268
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Coeur d' Alene Homes 10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) Christine c. (Last) Gilbertson

4. DATE OF DEATH (Month) Sept. (Day) 6, (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH March 8, 1876

9. AGE (In years last birthday) 93
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Sweden

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Not Available
BIRTHPLACE Sweden

14. MOTHER'S MAIDEN NAME Not Available
BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-01-0473D

17. INFORMANT'S OWN SIGNATURE Mrs. Pearl Prosser, Coeur d'Alene
ADDRESS Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1966, 19__, to Sept 6, 19 69, that I last saw the deceased alive on 9-1-, 19 69, and that death occurred at 1159 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS Hayden Lake Idaho

23c. DATE SIGNED 9-12 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-9-1969

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 15, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brueck

25. EMBALMER Bill Huff

LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene. Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 17 1969 Bureau of Vital Statistics

State File No. 4275
Local Reg. No. 257
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene c. LENGTH OF (Give this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace Nursing Home 340	d. STREET ADDRESS (If rural, give location): 210 West Lacrosse Ave.

3. NAME OF DECEASED (Type or Print) a. (First): Goldie	b. (Middle): Anna	c. (Last): Bernard	4. DATE OF DEATH (Month) (Day) (Year): Sept. 7, 1969		
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: July 18, 1885	9. AGE (In years last birthday): 84	IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Newton A. Luther	BIRTHPLACE: Iowa	14. MOTHER'S MAIDEN NAME: Susan Jane Risler	BIRTHPLACE: Iowa		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none	16. SOCIAL SECURITY NO.: 519-18-2554	17. INFORMANT'S OWN SIGNATURE: Mrs. Nada Hansen (BE)	ADDRESS: Sandpoint, Idaho		

4121

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Hemorrhage	1 day.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cardio-vascular Disease (Hypertension)	5 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Senility — — —	—

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1968, *to* Sept 7, 1969, *that I last saw the deceased alive on* Sept 7, 1969, *and that death occurred at* 6:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Rex Henson 225 (Degree or title) M.D.	23b. ADDRESS: Coeur d'Alene Idaho	23c. DATE SIGNED: Sept 9, 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 10, 69	24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery	24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho
DATE REC'D BY LOCAL REG.: Sept. 12, 1969	REGISTRAR'S SIGNATURE: Lorraine K. Brush	25. EMBALMER: Bill Duff	LICENSE NO.: E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 12 1970

JUL 29 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4276
Local Reg. No. 263
Reg. Dist. No. 120

RECEIVED SEP 17 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 2Yrs. 9Mon.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor Nur. Home 26

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 829 Third Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
IVA	E.	RINEHART	Sept. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Cau.	Married	1/15/1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife-School Tea.	Home-School	Minn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas McCracken	UNKNOWN	Mary J. Earl	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	517-01-7324B	Carl Rinehart	829 3rd. St. Coeur d' Alene, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

340X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonitis

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple sclerosis , decubitus ulcers
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10 , 19 63 , to 9-7 , 19 69 , *that I last saw the deceased alive on* 9-7 , 19 69 , *and that death occurred at* 8:50a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. T. Culbertson M.D.	Hayden Lake, Idaho 83835	9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/11/69	Restlawn	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 12, 1969	Lorraine K. Brush	Frank Houde	E-521

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 8 1969
OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4277
Local Reg. No. 264
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 17 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1419 Sherman

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 1419 Sherman

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joseph	Tracey	Sorensen	Sept. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Aug. 6, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Kaiser Aluminum	Georgetown, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hans Sorensen	Denmark	Mary Tippetts	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-09-1734	Mabel Freeman	Riverton, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

955X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Suicide by firearms — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gunshot wound through chest — 11
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ~~ACCIDENT~~ SUICIDE ~~HOMICIDE~~ (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide	Home	Coeur d'alene Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
m.		Shot himself through the chest

22. *I hereby certify that I attended the deceased from* Did not *, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
William T. Wood M.D. Coroner	Coeur d'alene, Idaho	9-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 11, 1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 12, 1969	Lorraine K. Brush	Bill Lenff	E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

SEP 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 17 1969 Bureau of Vital Statistics

State File No. 4278
Local Reg. No. 258
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai 28

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

LENGTH OF STAY (In this place) 4 Years

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor Nur. Home 061

d. STREET ADDRESS (If rural, give location) 2023 Seventh St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ESTHER	A.	BOYER	Sept. 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Cau.	Married	6/28/1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Spokane, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Martin Nelson	Norway	? Holly	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-40-6469-KI	Leo Boyer	2023 7th St. Coeur d' Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cerebrovascular Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-63, 19__, *to* 9-8, 19 69, *that I last saw the deceased alive on* 9-7-, 19 69, *and that death occurred at* 5 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Hayden Lake, Idaho 83835	9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/11/69	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 12, 1969	Lorraine K Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 17 1969

Bureau of Vital Statistics

State File No. 4279
Local Reg. No. 261
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootena i 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CdA.
c. LENGTH OF STAY IN THIS PLACE 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 721 S 12th

3. NAME OF DECEASED (Type or Print) a. (First) Clinton b. (Middle) L. c. (Last) Miller

4. DATE OF DEATH (Month) Sept (Day) 8 (Year) 1969

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 18 1890

9. AGE (In years last birthday) 79
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Clerk 03

10b. KIND OF BUSINESS OR INDUSTRY U.S.A.

11. BIRTHPLACE (State or foreign country) Osage Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Anton Miller
BIRTHPLACE Wis

14. MOTHER'S MAIDEN NAME Irene Whitney
BIRTHPLACE Wis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) W.W. I 3

16. SOCIAL SECURITY NO. 518 38 8233-A

17. INFORMANT'S OWN SIGNATURE Mrs. Dena Miller
ADDRESS CdA. Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 2509 Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension, asteriosclerosis — 4 years
DUE TO (c) Diabetes mellitus — 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-21, 1952 to 9-8, 1969, that I last saw the deceased alive on 9-8, 1969 and that death occurred at 6:20 PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 026

23b. ADDRESS Coeur d'Alene

23c. DATE SIGNED 9-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-10-69

24c. NAME OF CEMETERY OR CREMATORY Forest

24d. LOCATION (City, town, or county) CdA. (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 10, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Gilbert Yates

LICENSE NO. E-365

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 17 1969
DEC 4 1969
MAY 05 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4280
Local Reg. No. 260
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 — SEP 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Pinewood Manor Nur. Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rathdrum
d. STREET ADDRESS (If rural, give location) Rathdrum, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) EMILY b. (Middle) c. (Last) FARR
4. DATE OF DEATH (Month) (Day) (Year) Sept. 9, 1969

5. SEX: Female
6. COLOR OR RACE: Caul..
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 3/26/1878
9. AGE (In years last birthday): 91
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN — BIRTHPLACE: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN — BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Pinewood Manor Rec. — ADDRESS: Coeur d' Alene Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) C. V. D. with A. Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: Two Weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — Chronic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/6/62, 19____, *to* 9/9/69, 19____, *that I last saw the deceased alive on* 9/1/69, 19____, *and that death occurred at* 10:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Lynn C. Fredrickson (Degree or title) MD
23b. ADDRESS: Coeur d' Alene, Idaho
23c. DATE SIGNED: 9/10/69

24a. BURIAL / CREMATION / REMOVAL (Specify): Burial
24b. DATE: 9/12/69
24c. NAME OF CEMETERY OR CREMATORY: Pinegrove
24d. LOCATION (City, town, or county) (State): Rathdrum, Idaho

DATE REC'D BY LOCAL REG.: Sept. 12, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brueck
25. EMBALMER: Fred Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4281
Local Reg. No. 266
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 SEP 23 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 28
a. STATE Idaho b. COUNTY Kootenai

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur D' Alene

Bureau of Vital Statistics

c. LENGTH OF STAY in this place 11 Days

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Mem. Hospital 101

d. STREET ADDRESS (If rural, give location) Cd'A Homes Coeur d' Alene, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) OLIVE b. (Middle) c. (Last) BLUNT

4. DATE OF DEATH (Month) (Day) (Year) Sept. 10, 1969

5. SEX Female

6. COLOR OR RACE Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 1/12/1888

9. AGE (In years last birthday) 81

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook 21

10b. KIND OF BUSINESS OR INDUSTRY Hotel

11. BIRTHPLACE (State or foreign country) Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Zack Jarman

BIRTHPLACE UNKNOWN

14. MOTHER'S MAIDEN NAME Sarran Blackwell

BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 516-10-4699A

17. INFORMANT'S OWN SIGNATURE Nyla Bentz ADDRESS Post Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cerebral Arteriosclerosis — 10 days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/31, 19 69, *to* 9/10/69, 19____, *that I last saw the deceased alive on* 9/10/69, 19____ *and that death occurred at* 7:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE Marvin Buell (Degree or title) M.D. 917

23b. ADDRESS 920 Ironwood, Cd'A, ID

23c. DATE SIGNED 9-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/13/69

24c. NAME OF CEMETERY OR CREMATORY Thompson Falls City Cem.

24d. LOCATION (City, town, or county) (State) Thompson Falls, Mont.

DATE REC'D BY LOCAL REG. Sept 15, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Frank Houde

LICENSE NO. E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 23 1969
Bureau of Vital Statistics

State File No. 4282
Local Reg. No. 271
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Coeur d' Alene Homes 103	d. STREET ADDRESS (If rural, give location) Northwest Blvd. Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print)	a. (First) Katherine	b. (Middle) M.	c. (Last) Shanks	4. DATE OF DEATH (Month) Sept. (Day) 12, (Year) 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 23, 1886	9. AGE (In years last birthday) 83 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse 13	10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (State or foreign country) Scotland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McLain	BIRTHPLACE Scotland	14. MOTHER'S MAIDEN NAME Mary Ann MacRae	BIRTHPLACE Scotland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 519-16-2034	17. INFORMANT'S OWN SIGNATURE Art Olson (BE)	ADDRESS Coeur d'Alene, Idaho	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arterio sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* _____, 1952 *to* _____, 1969, *that I last saw the deceased alive on* Sept 11, 1969, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Dan Gummecht MD 192 (Degree or title)	23b. ADDRESS 502 W S Th	23c. DATE SIGNED 15 Sept 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-15-1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho
DATE REC'D BY LOCAL REG. Sept 19, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Leuff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 24 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4283
Local Reg. No. 267
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 23 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): E. 909 Garden

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Fred	C.	Collins	Sept. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 12, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
17	Lumber Mill	Bayfield, Wic.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
G. C. Collins	(Unobtainable)	Anna Olson	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (BE)	ADDRESS
Yes W. W. I 3	518-03-0896	Margaret Collins	Coeur d'Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CVA — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) previous CVA -

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-15-19 69 *to* 9-13-69, 19____, *that I last saw the deceased alive on* 9-13-69, 19____, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. M. Fanham MD	Hayden Lk. Idaho	9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-16-1969	Restlawn Memorial Pk.	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 19, 1969	Lorraine K. Brecht	Bill Neff	E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene, Ida.

SEP 23 1969
OCT 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 30 1969 Bureau of Vital Statistics

State File No. 4284
Local Reg. No. 281
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 818 Mill

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Evelyn	M.	Stover	Sept. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	10-23-1896	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher-Housewife 12		California	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herbert Crooks	(Unobtainable)	Florence E. Pierce	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (RE)	ADDRESS
no	none	543-44-5676	Clyde M. Stover	818 Mill Ave.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): **Acute myocardial infarction** — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): **Hypertensive arteriosclerotic cardio-vascular disease**
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-7, 1969, *to* 9-13, 1969, *that I last saw the deceased alive on* 9-12, 19 69, *and that death occurred at* 6:05 am *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. T. Culbertson M.D. 087	HAYDEN LAKE, IDAHO 83835	9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-16-1969	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29, 1969	Lorraine K. Brush	Bill Neff	E-439

FIRM NAME: English Chapel-Coeur d'Alene, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4285
Local Reg. No. 265
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai SEP 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
LENGTH OF STAY (In this place) 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 315 N. Sixth

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CARL	A.	BERGREN	Sept. 14 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau.	Never Married	2/27/1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rail Road Worker	Rail Road	Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	472-09-7909	Kootenai Mem Hosp. Rec.	Coeur d' Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebrovascular accident	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	Years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

4369

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5-16 , 1963, to 9-14 , 1969, *that I last saw the deceased alive on* 9-14 , 1969, *and that death occurred at* 3:25 PM *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G Barclay 026 M.D.		Coeur d'Alene	9-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 18, 1969	Lorraine K Brush	Fred Noland	E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 26 1969

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4286
Local Reg. No. 280
Reg. Dist. No. 120

BIRTH NO.

RECEIVED SEP 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hayden Lake
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hayden Lake Medical Clinic 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Rt. #1 Box 537

3. NAME OF DECEASED (Type or Print) a. (First) Charlie b. (Middle) R. c. (Last) Scott

4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept. 15, 1892

9. AGE (In years last birthday) 77 IF UNDER 1 YR. Months 0 Days 0 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister 18

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Cassius Scott BIRTHPLACE Unobt.

14. MOTHER'S MAIDEN NAME Fanniek K. Mullen BIRTHPLACE Unobt.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. One 3

16. SOCIAL SECURITY NO. 312-07-7868

17. INFORMANT'S OWN SIGNATURE Vernabelle Scott ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH Minute

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardio-Vascular Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28-68, 19__ to 9-15-, 1969, that I last saw the deceased alive on 6-30-69, 19__, and that death occurred at 10:30a m., from the causes and on the date stated above.

23a. SIGNATURE John M. Gunham M.D. (Degree or title)

23b. ADDRESS Hayden Lake, Idaho

23c. DATE SIGNED 9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-18-1969

24c. NAME OF CEMETERY OR CREMATORY Mountain View Cem.

24d. LOCATION (City, town, or county) Athol, (State) Idaho

DATE REC'D BY LOCAL REG. Sept 29, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER W. F. Ringlinger

LICENSE NO. E-397

FIRM NAME: English Chapel-Coeur d'Alene, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4287
Local Reg. No. 269
Reg. Dist. No. 120

BIRTH NO.

RECEIVED SEP 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 411 W. Linden 000	d. STREET ADDRESS (If rural, give location) 411 W. Linden

3. NAME OF DECEASED (Type or Print)	a. (First) Ray	b. (Middle) L.	c. (Last) Gooler	4. DATE OF DEATH (Month) (Day) (Year) September 16, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 19,1923	9. AGE (In years last birthday) 46 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Milltown, Montana	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unobtainable	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Unobtainable	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 4 W. W. II	16. SOCIAL SECURITY NO. 518-20-9317	17. INFORMANT'S OWN SIGNATURE (BE) Mrs May Gooler	ADDRESS Coeur d'Alene Idaho	

4369

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Probable Cerebrovascular accident	Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	arteriosclerosis	2 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. Coroner (Degree or title) 583 4	23b. ADDRESS Coeur d'alene Idaho	23c. DATE SIGNED 9-17-'69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept.20,69	24c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park	24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho
DATE REC'D BY LOCAL REG. Sept. 19, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Biplinger Jr.	LICENSE NO. E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 30 1969

State File No. 4288
Local Reg. No. 278
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY in this place: 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 920 N. 15th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Gerald	Edgar	O'Donald	Sept. 18 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 10, 1926	43		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender	Night Club	Jamestown, N. Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wilbur Edgar O'Donald		Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	502-14-5492	Helen O'Donald	Bovis

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Laennec's Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ~~Nobody~~
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Esophageal varices, ascites, jaundice and bronchopneumonia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-15-69, 19 *to* 9-18-69, 19 *that I last saw the deceased alive on* 9-18-69, 19 *and that death occurred at* 9:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Allen M. Parker MD	Hayden Lake, Idaho	9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	Sept. 22, 69	Moon Crematory	Sandpoint, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 26, 1969	Lorraine K Brush	Bill Duff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH--63021

SEP 3 0 1969
OCT 2 2 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 1 2 1983
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4289
Local Reg. No. 277
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 281 Kootenai SEP 30 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene c. LENGTH OF STAY (In this place) Bureau of Vital Statistics	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor Nursing Home 261	d. STREET ADDRESS (If rural, give location) 2514 N. 7th St.

3. NAME OF DECEASED (Type or Print) a. (First) Isabelle	b. (Middle)	c. (Last) Black	4. DATE OF DEATH (Month) Sept.	(Day) 20,	(Year) 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec.4, 1881	9. AGE (In years last birthday) 87	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Minnesota	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unobtainable	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Unobtainable	BIRTHPLACE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Bertha Brais (BE)	ADDRESS Tacoma, Washington		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1951, *to* Sept 20, 1969, *that I last saw the deceased alive on* Sept 18, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 192 (Degree or title) MD	23b. ADDRESS 302 W 5th	23c. DATE SIGNED 23 Sept 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept.24,69	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho
DATE REC'D BY LOCAL REG. Sept. 29, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER [signature]	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 1 0 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4290
Local Reg. No. 275
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 28/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 410 Sherman

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Roy	M.	Koester	Sept. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months, Days	IF UNDER 24 HRS. Hours, Min.
Male	White	Married	Sept. 6, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer-U.S. Gov't 08	Forestry	Forest City, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frederick Wm. Koester	Iowa	Fannie Morgan	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no / none	501-01-6755	Mrs Florence Koester	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5319

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Postoperative gastric resection — 2 weeks
DUE TO (c) Gastric ulcer — 6 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Sept 9, 1969	Gastric ulcer	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 1, 1969, *to* Sept. 20, 1969, *that I last saw the deceased alive on* Sept 20, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C E Thompson 530 MD	Coeur d'Alene, Idaho	Sept.25,69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept.25,69	St. Thomas Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept.29,1969	Lorraine K. Brush	W. K. Tyhurst Jr.	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4291
Local Reg. No. 276
Reg. Dist. No. 120

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 1925 Madina

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	ALFRED	MANN	Sept. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Cau.	Married	9/13/1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bottling Op
10b. KIND OF BUSINESS OR INDUSTRY: Pepsi Bottling Co.
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Mann	Virigina	Mary Johnson	California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO. 519-36-3322
17. INFORMANT'S OWN SIGNATURE: Lola Mann ADDRESS: 1925 Madina Coeur d' Alene, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4489

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 60, *to* present, 19____, *that I last saw the deceased alive on* 9-20-69, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: 920 Ironwood Dr. Coeur d'Alene, Idaho
23c. DATE SIGNED: 9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/25/69	Restlawn Mem. Park	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Sept 26 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Frank Houde
LICENSE NO.: E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics SEP 30 1969

State File No. 4292
Local Reg. No. 2442
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai (25)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place): 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp. (10)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai (28)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 727 Mill Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MILDRED	F.	PAGE	Sept. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cau.	Divorced	1/23/1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (07)	Own Home	Missouri	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis Mahler	Germany	Agustia Whittic	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	497-16-6424	T Patrica Page	727 Mill Ave. Coeur d' Alene, Ida.

4369

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebrovascular accident	5 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	arteriosclerosis	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-9, 1969, *to* 9-20, 1969, *that I last saw the deceased alive on* 9-20, 1969, *and that death occurred at* 7 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C Barclay M.D. (026)	Coeur d' Alene	9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/24/69	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 26, 1969	Lorraine K. Brush	Frank Houde	E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: OCT 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4293
Local Reg. No. 4293
Reg. Dist. No. 120

BIRTH NO.

RECEIVED SEP 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kooteani 28 | b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeurd' Alene | LENGTH OF STAY (in this place) 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho | b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene,
d. STREET ADDRESS (If rural, give location) 416 S. 11th. Cd'A, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	LESTER	ADAMS	Sept. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cau..	Divorced	1/17/11	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver 17	Logging	Michigan	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Adams	Michigan	Carrie Mc Kellar	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-01-0833	Charles Adams	820 Pine Ave. Coeur d' Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardiac arrest due to systemic toxins	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	gas gangrene	0
DUE TO (c)	open fracture both femurs	2-4hrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	pneumonia, delirium tremens, fatty ~~cirrhosis of liver~~	approx. 38 hours

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-20-69	open fractures both femurs	YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Street 04	Coeur d'Alene, Idaho Kootenai 28 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Sept. 20 1969 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Auto-Pedestrian accident

22. *I hereby certify that I attended the deceased from* 9-20, 1969, *to* 9-21, 19 69, *that I last saw the deceased alive on* 9-21, 1969, *and that death occurred at* 5:20 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William Gene Martin M.D.	920 Shorewood Dr.	9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/24/69	Forest Cemetery	Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 26, 1969	Lorraine K. Brueh	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

State File No. 4294
Local Reg. No. 282
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Marine Route

3. NAME OF DECEASED (Type or Print) a. (First) Harry b. (Middle) Edgar c. (Last) Wining

4. DATE OF DEATH (Month) Sept. (Day) 21, (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH April 17, 1916

9. AGE (In years last birthday) 53
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) //

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Somers, Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Howard Wining BIRTHPLACE Penn.

14. MOTHER'S MAIDEN NAME Gladys M. Boon BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. II 4

16. SOCIAL SECURITY NO. 516-14-6809

17. INFORMANT'S OWN SIGNATURE Mrs. Grace D. Wining ADDRESS Marine Route 2 Idaho Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4100 Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH 4 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. hypertension, obesity — 4 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-11, 1969 to 9-21, 1969, that I last saw the deceased alive on 9-21, 1969 and that death occurred at 9:45 A m., from the causes and on the date stated above.

23a. SIGNATURE [signature] 026 (Degree or title) M.D.

23b. ADDRESS Coeur d'Alene

23c. DATE SIGNED 9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 25, 69

24c. NAME OF CEMETERY OR CREMATORY Memorial Garden

24d. LOCATION (City, town, or county) Kalispell, Montana (State)

DATE REC'D BY LOCAL REG. Sept. 22, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brueck

25. EMBALMER Bill [illegible]

LICENSE NO. E-439

FIRM NAME English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 30 1969
DEC 18 2014

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED SEP 30 1969 Bureau of Vital Statistics

State File No. 4295
Local Reg. No. 277
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hopsital 101	d. STREET ADDRESS (If rural, give location) 1118 N. 4th St.

3. NAME OF DECEASED (Type or Print)	a. (First) S.	b. (Middle) Jane	c. (Last) Millikin	4. DATE OF DEATH (Month) (Day) (Year) Sept. 22, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 17, 1884	9. AGE (In years last birthday) 85 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Salinas, Calif.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unobtainable	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Unobtainable	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 519-56-6311	17. INFORMANT'S OWN SIGNATURE Patricia J Chase	ADDRESS	

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	myocardial infarct, acute	abrupt
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic heart disease decompensated	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1968, 19__, *to* 9-22, 1969, *that I last saw the deceased alive on* 9-22, 1969, *and that death occurred at* 1 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 251 M Hughes MD (Degree or title)	23b. ADDRESS Coeur D'Alene Idaho	23c. DATE SIGNED 9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept.24,69	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho
DATE REC'D BY LOCAL REG. Sept. 29, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Riplinger Jr.	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4296
Local Reg. No. 284
Reg. Dist. No. 120

RECEIVED
Bureau of Vital Statistics
OCT 10 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 b. CITY OR TOWN Coeur d' Alene (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place) 10 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION H. and D. Trailer Park 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Kootenai 281
c. CITY OR TOWN Coeur d' Alene
d. STREET ADDRESS (If rural, give location) H. and D. Trailer Park Cd'A

3. NAME OF DECEASED (Type or Print) a. (First) TERRY b. (Middle) c. (Last) BUCKMILLER

4. DATE OF DEATH (Month) (Day) (Year) Sept. 23, 1969

5. SEX Male

6. COLOR OR RACE Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH

9. AGE (In years last birthday) 10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03

10b. KIND OF BUSINESS OR INDUSTRY Grade School

11. BIRTHPLACE (State or foreign country) Kellogg, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Buckmiller BIRTHPLACE UNKNOWN

14. MOTHER'S MAIDEN NAME Josephene Glisson BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT'S OWN SIGNATURE Roy Glisson ADDRESS Coeur d' Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8907 Conflagration - House Trailer — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / ~~SUICIDE~~ HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01

21c. (CITY, TOWN, OR TOWNSHIP) Coeur d'alene (COUNTY) Kootenai 281 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? House Trailer Burned

22. *I hereby certify that I attended the deceased from* Did Not, 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 583 William T. Wood M.D. Coroner

23b. ADDRESS Coeur d'alene Idaho

23c. DATE SIGNED 9-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/29/69

24c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Oct. 2, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred Noland LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 10 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4297
Local Reg. No. 286
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
OCT 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai (28)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital (10)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai (40)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 8 West Mission

3. NAME OF DECEASED (Type or Print): a. (First) Katherine; b. (Middle) B.; c. (Last) Cook

4. DATE OF DEATH: (Month) Sept. (Day) 27, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 28, 1899

9. AGE (In years last birthday): 69
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (01)

10b. KIND OF BUSINESS OR INDUSTRY: House-Own

11. BIRTHPLACE (State or foreign country): Denver, Colorado

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Brayer — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Barbara Southerland — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 557-32-6551a

17. INFORMANT'S OWN SIGNATURE: Marian C. Waltman — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Bilateral fractures: tibias & fibulae — INTERVAL BETWEEN ONSET AND DEATH: 1½ hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Street

21c. (CITY, TOWN, OR TOWNSHIP): Coeur d'Alene (COUNTY): (28) Kootenai (STATE): Idaho

21d. TIME OF INJURY: (Month) Sept (Day) 27 (Year) 1969 (Hour) 7:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ~~Sept 27~~, 1969, to 9-27, 1969, that I last saw the deceased alive on Sept 27, 1969, and that death occurred at 9 p.m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] (530) (Degree or title): MD

23b. ADDRESS: 920 Ironwood Dr. Coeur d'Alene Idaho

23c. DATE SIGNED: 10-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 1, 1969

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct. 7, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Bill Duff

LICENSE NO.: E-439

FIRM NAME: Maisel Chapel-Kellogg

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 10 1969
APR 13 1971 OCT 17 1969
DEC 11 1972
APR 6 1973
JAN 03 1996

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4298
Local Reg. No. 283
Reg. Dist. No. 120

RECEIVED OCT 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

c. LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai 28

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

d. STREET ADDRESS (If rural, give location) 1113 St. Maries Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Carl b. (Middle) A. c. (Last) Buck

4. DATE OF DEATH (Month) (Day) (Year) September 30, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH March 27, 1889

9. AGE (In years last birthday) 80

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 11

10b. KIND OF BUSINESS OR INDUSTRY Builder

11. BIRTHPLACE (State or foreign country) Denmark

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unobtainable BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unobtainable BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-01-9887

17. INFORMANT'S OWN SIGNATURE (BE) Carla M. Buck ADDRESS Coeur d'Alene Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease with Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 9.25.69

19b. MAJOR FINDINGS OF OPERATION Multiple Stones in Common Bile Duct

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/19, 1969, to 9.30, 1969, that I last saw the deceased alive on 9/30, 1969, and that death occurred at 12:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD, 313

23b. ADDRESS Coeur d'Alene, Idaho

23c. DATE SIGNED 10-2-1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE Oct.2,69

24c. NAME OF CEMETERY OR CREMATORY Moon's Crematory

24d. LOCATION (City, town, or county) Sandpoint, (State) Idaho

DATE REC'D BY LOCAL REG. Oct 3,1969

REGISTRAR'S SIGNATURE Lorraine K Brush

25. EMBALMER Bill Duff

LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4299
Local Reg. No. 287
Reg. Dist. No. 120

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28 OCT 10 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3rd. and Spokane 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48 b. COUNTY Spokane 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) W. 2318 Dean

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LILA	ANN	CROCKETT	Sept. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	9-4-1931	38				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Pocatello, Idaho	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ransom Kimpton		Nellie Dixon	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Nellie D. Johnson	2318 W. Dean-Spokane,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Automobile - Pedestrian — INTERVAL BETWEEN ONSET AND DEATH: Instn.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) accident.
DUE TO (c) Multiple Crush injuries. — Sudden

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 28 (COUNTY) (STATE)
accident	City Street 04	Coeur d'alene Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Car struck her in street.

22. *I hereby certify that I attended the deceased from* Did Not, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Dood, M.D. 583 4	Coroner	Coeur d' Alene Idaho	10-4-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	9-30-1969	Fairmount Memorial Park	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 7, 1969	Lorraine K. Brush	Frank Houde	E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4300
Local Reg. No. 97
Reg. Dist. No. 200

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 SEP 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
d. STREET ADDRESS (If rural, give location): 5 miles North of Potlatch

3. NAME OF DECEASED (Type or Print)
a. (First): LAWRENCE
b. (Middle): JOSEPH
c. (Last): MACKAY

4. DATE OF DEATH (Month) (Day) (Year): September 2, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 5, 1888
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Wheat Farm-Lumber
11. BIRTHPLACE (State or foreign country): Colfax, Washington
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: James Mackay — BIRTHPLACE: Quebec, Canada
14. MOTHER'S MAIDEN NAME: Emily Woodman — BIRTHPLACE: Cambridge, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 518-01-0198
17. INFORMANT'S OWN SIGNATURE: Irene Mackay — ADDRESS: Route 1, Potlatch, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) myocardial infarction
DUE TO (c) coronary atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 24 m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. B. Fritzmann 057 Coroner
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 3/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-4-69
24c. NAME OF CEMETERY OR CREMATORY: Palouse Fraternal Cemetery
24d. LOCATION (City, town, or county) (State): Palouse, Washington

DATE REC'D BY LOCAL REG.: 8 Sept 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: H. E. Kimball
LICENSE NO.: E269

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4301
Local Reg. No. 98
Reg. Dist. No. 200

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN: Moscow
LENGTH OF STAY (in this place): 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 29

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 521 So. Lincoln

3. NAME OF DECEASED (Type or Print): a. (First) Sarah b. (Middle) Ann c. (Last) Petersen

4. DATE OF DEATH: (Month) Sept. (Day) 2 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: August 4, 1906
9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hannibal Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Pratt — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Edith Manuel — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-28-0813
17. INFORMANT'S OWN SIGNATURE: X Wesley Petersen — ADDRESS: Moscow, Idaho

2509

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Complications of Arteriosklerosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Mellitus — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arthritis.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1968, *to* 9-2, 1969, *that I last saw the deceased alive on* 8-15, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: O Denny 148 (Degree or title): M.D.
23b. ADDRESS: Troy Idaho
23c. DATE SIGNED: 9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 5 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 8 Sept 1969
REGISTRAR'S SIGNATURE: Maynard Reichart
25. EMBALMER: Donald Ward
LICENSE NO.: E-80

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4302
Local Reg. No. 94
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 7 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Genesee
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Susan
b. (Middle)
c. (Last) Winterfelt

4. DATE OF DEATH (Month) Sept. (Day) 3, (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Nov. 17, 1903

9. AGE (In years last birthday) 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HD

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Genesee, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Winterfelt — BIRTHPLACE Chicago, Illinois

14. MOTHER'S MAIDEN NAME Lena Tibolt — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-58-7327

17. INFORMANT'S OWN SIGNATURE Elmer Winterfelt — ADDRESS Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Day's

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gastroenteritis
DUE TO (c) Pneumonia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 67, 1967, *to* Sept. 3, 1969, *that I last saw the deceased alive on* Sept. 3, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward L Boas 788 (Degree or title) MD

23b. ADDRESS Moscow, Idaho

23c. DATE SIGNED 9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried

24b. DATE Sept. 5, 1969

24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery

24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 5 Sept 1969

REGISTRAR'S SIGNATURE Wayne R Heiskari

25. EMBALMER E. Pete Albertson — LICENSE NO. E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4303
Local Reg. No. 96
Reg. Dist. No. 200

BIRTH NO.

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 11 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tensed
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Herman	Edwin	Osterberg	Sept.	4	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Widowed	April 27, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woodsman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John F. Osterberg — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Selma Johnson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-03-7556
17. INFORMANT'S OWN SIGNATURE: x Mrs Johnnie Foote — ADDRESS: Tensed, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes Mellitus — years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1954, *to* Sept 4, 1969, *that I last saw the deceased alive on* Sept 4, 1969, *and that death occurred at* 7:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W B Adams MD	Moscow, Idaho	9/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-8-1969	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-12-69	Dolores Letterman (Deputy)	E. Pete Albertson	E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 22 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4304
Local Reg. No. 95
Reg. Dist. No. 200

BIRTH NO.

RECEIVED SEP 15 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 318 S. Almon

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lena	R.	Sleep	Sept. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 16, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Whitewater, Wisc.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Krichbaum — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Caroline unknown — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-01-8296A
17. INFORMANT'S OWN SIGNATURE: Melvin R Sleep — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	INTERVAL BETWEEN ONSET AND DEATH
	Cerebral Vascular accident	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*	DUE TO (b) Hypertension con't	
	DUE TO (c) Diabetes Mellitus	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Obesity	

25509

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 8, 19 69, to Sept 9, 19 69, *that I last saw the deceased alive on* ____, 19 ____, *and that death occurred at* 12:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title)
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 9-12-69
REGISTRAR'S SIGNATURE: Dolores Litterman Deputy
25. EMBALMER: E Pete Albertson
LICENSE NO.: E-525
FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4305
Local Reg. No. 101
Reg. Dist. No. 200

RECEIVED
SEP 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 40 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Ora
b. (Middle): May
c. (Last): Liberg

4. DATE OF DEATH (Month) (Day) (Year): Sept. 14 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 20, 1902
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cottonwood, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Bert Howard Oliver — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Laura Morrison — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Lars J. Liberg — ADDRESS: Genesee, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic myocarditis with failure
DUE TO (c) Carcinoma of stomach with possible brain metastases

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Paralized bladder & lower legs Spinal cord tumor
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18-, 1965, *to* 9-14-, 1969, *that I last saw the deceased alive on* 8-31, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph T. Wilson MD 567
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 9-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Genesee City
24d. LOCATION (City, town, or county): Genesee — (State): Idaho

DATE REC'D BY LOCAL REG.: 22 Sept 1969
REGISTRAR'S SIGNATURE: Mayne R Heiskari
25. EMBALMER: E. Pete Albertson — LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4306
Local Reg. No. 103
Reg. Dist. No. 200

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291 SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (In this place) 2 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 319 S. Lilly

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ada	Lillian	Bolander	Sept. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	April 14, 1899	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Managed Nursing Home 24		Oakley, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Ace Pool	Indiana	Della Kayler	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-09-5124	Paul E. Bolander	San Jose, Cal.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2509 Arteriosclerotic Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1959, *to* Sept 15, 1969, *that I last saw the deceased alive on* 9-15-, 1969, *and that death occurred at* 9:06 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Omer H Drury 148	MD	Troy Idaho	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 18, 1969	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
25 Sept 1969	Wayne K Heiskell	E. Pete Albertson	E-525

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4307
Local Reg. No. 102
Reg. Dist. No. 200

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 241 SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 1205 East 3rd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Norma	Jean	Curtis	Sept. 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	white	Married	May 12, 1927	42		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nurse 13	Nursing	Columbus, Ohio	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oris Bertram Wells	Caldwell, Ohio	Freda M. Hambel	Akron, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	701-28-7470	John H. Curtis	Moscow, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1533 Carcinoma of Sigmoid Colon — INTERVAL BETWEEN ONSET AND DEATH: 9 Months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 21, 1969, *to* Sept 16, 1969, *that I last saw the deceased alive on* Sept 15, 1969, *and that death occurred at* 6:10A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D Rodams MD	Moscow, Idaho	Sept 21, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Sept. 18, 1969	Memorial Park	Zanesville, Ohio

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
29 Sept 1969	Wayne R Heikkari	E. Pete Albertson	E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED OCT 6 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4308
Local Reg. No. 104
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 29 b. CITY OR TOWN Moscow c. LENGTH OF STAY (in this place) 1 Hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 209 No Garfield

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Maureen	Louise	Connelly	Sept.	19,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	Feb. 24, 1953	16				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	High School	Moscow, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leland Connelly	Lawton, N. D.	Doris Erickson	North Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-66-3571	X Jessica Connelly	Moscow, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8139 Probable Subdural Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Autoaccident

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) !

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 04

21c. (CITY, TOWN, OR TOWNSHIP) Moscow (COUNTY) Latah 29 (STATE)

21d. TIME OF INJURY (Month) 9 (Day) 19 (Year) 69 (Hour) 7:30 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Two car accident

22. *I hereby certify that I attended the deceased from* 9-19, 1969 *to* 9-19, 1969 *that I last saw the deceased alive on* 9-19, 1969, *and that death occurred at* 10:15 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David C Valder	541 MD	Moscow, Idaho	9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Sept. 23, 1969	Moscow Catholic Cemetery	Moscow	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
29 Sept 1969	Maynard Heiskari	E. Pete Albertson	E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. DEC 5 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to MAR 14 2011

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4309
Local Reg. No. 105
Reg. Dist. No. 200

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 OCT 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (If in this place): 3 Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Own Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 292
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Glen
b. (Middle): Henry
c. (Last): Mc Williams

4. DATE OF DEATH (Month) (Day) (Year): Sept. 24 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 9, 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Livestock Dealer 22
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Eaton, Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: W. Henry McWilliams — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Cora Alice Williams — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-03-8928
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: GENESEE, IDA.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: unused

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary atherosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 5 P m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 057 (Degree or title) Mc Coroner
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 9/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-29-1969
24c. NAME OF CEMETERY OR CREMATORY: Genesee Catholic
24d. LOCATION (City, town, or county): Genesee (State): Idaho

DATE REC'D BY LOCAL REG.: 2 Oct 1969
REGISTRAR'S SIGNATURE: Wayne R. Heiskari
25. EMBALMER: E. Pete Albertson — LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4310
Local Reg. No. 106
Reg. Dist. No. 200

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 290 OCT 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6 Miles East of Moscow 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) Gault Hall--- West 6th St.

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) Craig
c. (Last) Robinson

4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1969

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH May 5, 1949
9. AGE (In years last birthday) 20 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY University of Idaho
11. BIRTHPLACE (State or foreign country) Ft. Collins, Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME A. B. Robinson — BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Martha Burney — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-56-8217
17. INFORMANT'S OWN SIGNATURE A.K. Robinson — ADDRESS Oxford, Miss.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 955X Cerebral hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 22 cal. bullet
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE/HOMICIDE 2 (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) woods E. Moscow
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 290 Latah (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 24 69 ? m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? self inflicted

22. *I hereby certify that I attended the deceased from _____, 19__ to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 057 (Degree or title) J. L. Brotzmann M.D. Coroner
23b. ADDRESS Moscow, Idaho
23c. DATE SIGNED 9/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Sept. 30, 1969
24c. NAME OF CEMETERY OR CREMATORY Beckman-Butherus Funeral
24d. LOCATION (City, town, or county) (State) Home Iowa City, Iowa

DATE REC'D BY LOCAL REG. 2 Oct 1969
REGISTRAR'S SIGNATURE Wayne R. Heiskari
25. EMBALMER Donald Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4311
Local Reg. No. 107
Reg. Dist. No. 200

RECEIVED OCT 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 22 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 529

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mabel		Kitts	Sept.	28	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	July 29, 1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Gale	Wisconsin	Hanna Unknownn	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-32-5127	X Dale L. Murphy	Coeur D'Alene IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4510

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) pulmonary embolism
DUE TO (c) thrombophlebitis leg

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 1969 *to* Sept 1969 *that I last saw the deceased alive on* 30 Sept 1969 *and that death occurred at* 3 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 057 MD	Moscow, Idaho	10/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 30, 1969	Moscow Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
30 Oct 1969	Wayne R Heiskari	Donald Ward	E-30

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4312
Local Reg. No. 112
Reg. Dist. No. 200

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): Caroline
c. (Last): Mengelkamp

4. DATE OF DEATH (Month) (Day) (Year): Sept. 28 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: January 25, 1894
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Uniontown, Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Herman Striebeck — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 532-46-4578
17. INFORMANT'S OWN SIGNATURE: X Mrs. Oris Barbour — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis, General — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 25, 1969, *to* Sept 28, 1969, *that I last saw the deceased alive on* Sept 28 1969, *and that death occurred at* 2:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W E Adams, MD 001
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Fairmont Memorial Park
24d. LOCATION (City, town, or county) (State): Spokane Washington

DATE REC'D BY LOCAL REG.: 6 Oct 1969
REGISTRAR'S SIGNATURE: Wayne R. Heiskari
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4313
Local Reg. No. 111
Reg. Dist. No. 200

BIRTH NO. 69-9455

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 12

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1 Box 353 A

3. NAME OF DECEASED (Type or Print): a. (First) Michael b. (Middle) Robert c. (Last) Otto

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 30, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Sept. 29, 1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days: 1 | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 0 2

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Moscow, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Leo Otto — BIRTHPLACE: St. Louis, Mo.

14. MOTHER'S MAIDEN NAME: Julie Lea Johnson — BIRTHPLACE: Harvey, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: X Robert L Otto — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 16 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept 29, 1969, *to* Sept 30, 1969, *that I last saw the deceased alive on* ~~Sept. 30~~, 1969, *and that death occurred at* 12:25 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): [signature] M.D.
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: Oct. 6, 196

24a. BURIAL, CREMATION, REMOVAL (Specify): Buried
24b. DATE: Oct. 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Catholic Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 8 Oct 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskeri
25. EMBALMER: Donald Ward
LICENSE NO.: E-30
FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4314
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 300 LEMHI OCT 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
c. LENGTH OF STAY (In this place) 38 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Casabello Estate 272

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle)
c. (Last) Weidman

4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May 15, 1880
9. AGE (In years last birthday) 89 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mining 07
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Gerrardstown, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Weidman — BIRTHPLACE W. Va.
14. MOTHER'S MAIDEN NAME Jane Heronimous — BIRTHPLACE Virginia ~~Unknown~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-03-8070
17. INFORMANT'S OWN SIGNATURE + Viola Weidman Evans — ADDRESS San.Fran. Calif

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c) Generalized — 10 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1949, *19*__, *to* Prescott, *19*__, *that I last saw the deceased alive on* 9-23, *19*69 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE W. H. Hartsdale, M.D. (Degree or title) 045
23b. ADDRESS Salmon Ida
23c. DATE SIGNED 10-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 30, 1969
24c. NAME OF CEMETERY OR CREMATORY Salmon
24d. LOCATION (City, town, or county) (State) Salmon, Idaho

DATE REC'D BY LOCAL REG. Oct 6th 69
REGISTRAR'S SIGNATURE Viola E. Johnson
25. EMBALMER Delbert C. Jones — LICENSE NO. E 369

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Jones Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4315
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi — OCT 8 1969
b. CITY OR TOWN: Salmon
c. LENGTH OF STAY (in this place): 15 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casabello Estate

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Oren	O'Brien	Sept. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	never married	Dec. 20, 1873	95				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mining 07		Manistique, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James P. O'Brien	Candda	Mary Ann Touhey	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	Taken from papers	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerosis

DUE TO (c) Arteriosclerosis + Arteriosclerotic Cardiovascular dis, 10y

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1955, 19___, *to* Present, *that I last saw the deceased alive on* 9-23-, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 045 MD	Salmon Ida	10-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 30. 1969	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 6th 69	Viola E. Johnson	Delbert H. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4316
Local Reg. No. 299
Reg. Dist. No.

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 302 OCT 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (In this place): 16 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casabello Estate 272

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 302
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): May
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): Emily
c. (Last): Brown

4. DATE OF DEATH (Month) (Day) (Year): Sept. 29, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 1, 1919

9. AGE (In years last birthday): 50
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baker, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Hill
BIRTHPLACE: Millville, Utah

14. MOTHER'S MAIDEN NAME: Emily
BIRTHPLACE: nr. Idaho Falls, Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT'S OWN SIGNATURE: X Daneye Brown
ADDRESS: May, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3480

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Amyotrophic Lateral Sclerosis
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8/23, 1966, *to* 9-29, 1969, *that I last saw the deceased alive on* 9-25, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 263 Zach A. Johnson, M.D.
23b. ADDRESS: Box 769, Salmon, Idaho
23c. DATE SIGNED: 10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Oct 6th 69
REGISTRAR'S SIGNATURE: Viola E Johnson
25. EMBALMER: Delbert C Jones
LICENSE NO.: E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 8 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4317
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

OCT 8 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 58 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Harry	Lorenzo	Jones	Sept. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Apr. 4, 1907	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
painter 21		Dillon, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Thomas Jones	Canada	Cora Edna Preston	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW 2 4	518-18-5560	Lyla Jones	Salmon, Idaho

955-X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound of head — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Fracture Skull - extensive brain damage	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide	Home 31	13300

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
9 30 69 12:10 A.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	

22. *I hereby certify that I attended the deceased from* 2/18, 1964, *to* 9/30, 1969, *that I last saw the deceased alive on* 9/30, 1969, *and that death occurred at* 7:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
263 Zach A. Johnson, M.D.	Box 769, Salmon, Idaho	10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 2, 1969	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 6th 69	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 14 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 27 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

SEP 18 1970

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

OCT 1 1974

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

JUN 6 1990

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED SEP 10 1969 STATE OF IDAHO

State File No. 4318
Local Reg. No. 244
Reg. Dist. No. 430

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (In this place): —
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Charles b. (Middle) Wallace (Chick) c. (Last) Gwin

4. DATE OF DEATH: (Month) Sept. (Day) 7, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 6, 1896

9. AGE (In years last birthday): 72 | IF UNDER 1 YEAR: Months 11 Days 1 | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Justice of Peace 08

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Shoshone, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Franklin P. Gwin — BIRTHPLACE: California

14. MOTHER'S MAIDEN NAME: Anna J. Wallace — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519-10-2148

17. INFORMANT'S OWN SIGNATURE: X Mrs. Elsie E. Gwin — ADDRESS: Shoshone, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema — 5 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 19 69, to Sept 7, 1969, that I last saw the deceased alive on Sept 2, 1969, and that death occurred at 7:10 m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] 386 (Degree or title)
23b. ADDRESS: 368 Shoshone Idaho
23c. DATE SIGNED: 9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-10-1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 9-8-1969
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4319
Local Reg. No. 695
Reg. Dist. No. 430

BIRTH NO.

RECEIVED
SEP 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (In this place): 240
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalscent Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Carey
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Margaret	Eva	McCrosky	Sept. 16 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Fe.	Wht	Widowed	Aug. 12, 1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 28		Omaha, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mojanet Potter	England	Anna Kathrine Long	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-16-1304A	Anne Brodie	Carey.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4410 Disseminated Rocky Mountain Spotted Fever — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease — 10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 6, 1969 *to* Sept 16, 1969, *that I last saw the deceased alive on* Sept 15, 1969, *and that death occurred at* 12:20 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD 386	Box 68 Hailey Ida	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-18-69	Hailey Cemetery	Hailey Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-22-69	Francis M. Bergin	Keith Bird [signature]	E-373

FIRM NAME: Bird Funeral Home Hailey, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4320
Local Reg. No. 56
Reg. Dist. No. 630

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Madison 331 SEP 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg Bureau of Vital Statistics
c. LENGTH OF STAY (If outside place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison 330
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) Rt 1,

3. NAME OF DECEASED (Type or Print)
a. (First) Whitney
b. (Middle) Napoleon
c. (Last) Squires

4. DATE OF DEATH (Month) (Day) (Year) Sept. 2,1969

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 5,1892
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hyrum, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Henry Squires — BIRTHPLACE Salt Lake City, Utah
14. MOTHER'S MAIDEN NAME Christine Anderson — BIRTHPLACE Oslo, Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-24-1126
17. INFORMANT'S OWN SIGNATURE Reed E. Squires — ADDRESS 132 East 1st So. Rexburg, Idaho 83440

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Posterior Coronary — INTERVAL BETWEEN ONSET AND DEATH 6 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Occlusion

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct., 1957, *to* Sept-2, 1969, *that I last saw the deceased alive on* 9-2, 1969 *and that death occurred at* 3:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE M F Rigby MD 442 (Degree or title)
23b. ADDRESS Rexburg Idaho
23c. DATE SIGNED 9-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/6/69
24c. NAME OF CEMETERY OR CREMATORY Rexburg Cemetery
24d. LOCATION (City, town, or county) Rexburg, Madison, (State) Idaho

DATE REC'D BY LOCAL REG. 9-6-69
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER Russel Flamm
LICENSE NO. E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4321
Local Reg. No. 55
Reg. Dist. No. 630

BIRTH NO.

RECEIVED Bureau of Vital Statistics SEP 17 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: SL County 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salt Lake City
d. STREET ADDRESS (If rural, give location): 3185 So. 4 East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	Carl	Whitaker	Sept. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Married	June 10, 1913	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Waddy, Kentucky	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Thomas Whitaker	Normandy, Kentucky	Margaret Ann Montgomery	Anderson, Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	400-18-2969	Ronald C Whitaker	Rt 1, Box 304, Thornton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 7, 1969, *to* Sept 7, 1969, *that I last saw the deceased alive on* Not Seen, 19__, *and that death occurred at* 5:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Blaine Woodsey 409 MD	Rexburg Idaho	9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	9/8/69	Redwood Memorial Estates	Salt Lake City, SLC., Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-8-69	Leona Flamm	Russell Flamm	E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4322
Local Reg. No. 57
Reg. Dist. No. 630

BIRTH NO. 69-9314

RECEIVED OCT 7 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH 331
a. COUNTY Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony-Rural
d. STREET ADDRESS (If rural, give location) RFD#2

3. NAME OF DECEASED (Type or Print)
a. (First) Jennifer
b. (Middle) Diane
c. (Last) Ours

4. DATE OF DEATH (Month) (Day) (Year) Sept., 12, 1969

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Sept., 12, 1969
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 4 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Anthony, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE
14. MOTHER'S MAIDEN NAME Kathleen Ours BIRTHPLACE Pickwick County, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Kathleen M. Ours ADDRESS St. Anthony, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-12, 1969, *to* 9-12, 1969, *that I last saw the deceased alive on* 9-12, 1969, *and that death occurred at* 6 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Lester J. Petersen MD 413 (Degree or title)
23b. ADDRESS Rexburg Idaho
23c. DATE SIGNED 9-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 13 Sept 69
24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery
24d. LOCATION (City, town, or county) (State) St. Anthony, Idaho

DATE REC'D BY LOCAL REG. 9/17/69
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER M. D. Hansen
LICENSE NO. E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4323
Local Reg. No. 328
Reg. Dist. No. 630

RECEIVED
Bureau of Vital Statistics
OCT 7 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison (331)
b. CITY OR TOWN: Rexburg
LENGTH OF STAY (in this place): 7 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rexburg Nursing Home 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Olive	Jessie	Brown Macdonald	Sept.	16,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Widowed	Jan. 28, 1877	92				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 176
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Winnipeg, Manitoba, Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Brown	Ontario, Canada	Maria S. Mac Dougall	Ontario, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Gertrude Brown. ADDRESS: Toronto Dominion Bank 1000 Robson St. Bank B.C.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	4867 Pneumonia	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	[illegible]	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic Cerebral Vascular disease	several yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1962, to 9-16, 1969, that I last saw the deceased alive on 9-15, 1969, and that death occurred at 4 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lester Tolersen M.D.	413	Rexburg Idaho	9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/19/69	Pine View Cemetery	Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-19-69	Leona F. Lamm	Robert V. Dean	E-456

FIRM NAME: Robert Dean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4324
Local Reg. No. 59
Reg. Dist. No. 630

BIRTH NO. 69-5506 RECEIVED

Certificate of Death

STATE OF IDAHO

Bureau of Vital Statistics OCT 7 1969

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 4 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 165 N. 3rd E.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 165 N. 3rd East.

3. NAME OF DECEASED (Type or Print): a. (First) MICHAEL b. (Middle) "L" c. (Last) ARCHIBALD

4. DATE OF DEATH (Month) (Day) (Year): Sept. 23, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: June 4, 1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months: 3 Days: 19 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael LaMar Archibald — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Laura Lee Bell — BIRTHPLACE: Albion, Idaho.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Victor L Chandler — ADDRESS: Rexburg, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute respiratory obstruction — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Inhalation of vomitus.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* XXXX

DUTIES:

OCT 28 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4325
Local Reg. No. 60
Reg. Dist. No. 630

RECEIVED
OCT 7 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 220 S 2 W

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Hugh
c. (Last): Sharp

4. DATE OF DEATH (Month) (Day) (Year): Sept. 26, 1969

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 13. 1891
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer- Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Smithfield, Utah
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Francis Sharp — BIRTHPLACE: Smithfield, Utah
14. MOTHER'S MAIDEN NAME: Lydia Ann Pilkington — BIRTHPLACE: Smithfield, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 519-07-4073
17. INFORMANT'S OWN SIGNATURE: William M. Sharp — ADDRESS: Rexburg, Idaho

4189

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis — several yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Pulmonary emphysema — several yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1969, *to* Sept 23, 1969, *that I last saw the deceased alive on* 9-23, 1969, *and that death occurred at* 8 10 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lester J. Petersen MD 413
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/29/69
24c. NAME OF CEMETERY OR CREMATORY: Sutton, Cemetery
24d. LOCATION (City, town, or county) (State): Archer, Madison, Idaho

DATE REC'D BY LOCAL REG.: 9-29-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Russel Flamm
LICENSE NO.: E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4326
Local Reg. No. 69
Reg. Dist. No. 630

RECEIVED
OCT 7 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 330
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sugar City
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Olive
b. (Middle): Lorraine Cluff
c. (Last): Orme

4. DATE OF DEATH (Month) (Day) (Year): Sept. 26, 1969

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 15, 1897
9. AGE (In years last of life): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Heber City, Utah
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Robert William Cluff — BIRTHPLACE: Provo, Utah
14. MOTHER'S MAIDEN NAME: Martha Elizabeth Heaton — BIRTHPLACE: Payson, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-42-9533A
17. INFORMANT'S OWN SIGNATURE: John K. Orme — ADDRESS: Sugar City, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5340

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastro Intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Probable ulcer — several yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 23, 1969, *to* 9-26, 1969, *that I last saw the deceased alive on* 9-26, 1969, *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lester J. Peterson MD 413
23b. ADDRESS:
23c. DATE SIGNED: 9-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/30/69
24c. NAME OF CEMETERY OR CREMATORY: Sugar City Cemetery
24d. LOCATION (City, town, or county) (State): Sugar City, Madison, Idaho

DATE REC'D BY LOCAL REG.: 9-30-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Russel F. Flamm — LICENSE NO. E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4327
Local Reg. No. 66
Reg. Dist. No. 450

RECEIVED
SEP 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 340
a. COUNTY: Minidoka County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 710 5th street(home) 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 710 5th street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Homer	W.	Christiansen	Sept 6 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Oct. 28, 1904	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Union Pacific Rail 10	Way Engineer	Storm Lake Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Martin L Christiansen	Minnesota	Fransis Hansen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	712-09-0833	X Mrs. H. W. Christiansen	Rupert Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2001

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphoblastic lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: Few months.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1966, *to* 6 Sept, 1969, *that I last saw the deceased alive on* 6 Sept, 1969, *and that death occurred at* 9:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J W Crawford 340 MD	Rupert Idaho	9 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 9 1969	Rupert Cemetery	Rupert Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-12-69	Mary Ellen Larson	Robert C Walk	E 294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 22 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 1 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 22 1969

FEB 8 1973

JUN 22 1982

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 24 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4328
Local Reg. No. 68
Reg. Dist. No. 45C

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 200 north 253 west

3. NAME OF DECEASED (Type or Print) a. (First) Domenica b. (Middle) c. (Last) Criston

4. DATE OF DEATH (Month) (Day) (Year) Sept 22 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH May 27 1879

9. AGE (In years last birthday) 90 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Tyrol Austria

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE Cipriano Pedrotti--Tyrol Austria

14. MOTHER'S MAIDEN NAME BIRTHPLACE Rosa De Guliana--Tyrol Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-58-8354

17. INFORMANT'S SIGNATURE ADDRESS Mary Criston Anson

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia, acute — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute respiratory disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. General debility of age

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 17 Sept, 1969, to 22 Sept, 1969, that I last saw the deceased alive on 22 Sept, 1969, and that death occurred at 12:00 p. m., from the causes and on the date stated above.

23a. SIGNATURE W. W. Crawford 340 (Degree or title) MD

23b. ADDRESS Rupert Idaho

23c. DATE SIGNED 23 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 9-25-69

24c. NAME OF CEMETERY OR CREMATORY Norway City Cemetery

24d. LOCATION (City, town, or county) (State) Norway Michigan

DATE REC'D BY LOCAL REG. 9-23-69

REGISTRAR'S SIGNATURE Mary Ellen Barlow

25. EMBALMER Charles L. Parsons

LICENSE NO. E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: SEP 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4329
Local Reg. No. 70
Reg. Dist. No. 450

BIRTH NO.

RECEIVED
340 SEP 29 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert (rural)
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 200 North - 400 West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert (rural)
d. STREET ADDRESS (If rural, give location): 200 North - 400 West

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ernest	Alonzo	BROWN, Sr.	Sept. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 23, 1908	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Lorene, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Willis Edwin Brown	unknown	Hulda Peters	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War II	571-10-4098	Edward R. Brown	Rupert, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease & decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Asthma

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 26 Oct, 1966, *to* 23 Sept, 1969, *that I last saw the deceased alive on* 23 Sept, 1969, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. W. Crawford 340	MD	Rupert, Idaho	25 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 30, 1969	Paul Cemetery	Paul, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-26-69	Mary Ellen Carlson	Charles L. Perano	E-494

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Walk Mortuary

DUTIES: OCT 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4330
Local Reg. No. 73
Reg. Dist. No. 450

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 OCT 7 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
c. LENGTH OF STAY (in this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 402 North Main Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
d. STREET ADDRESS (If rural, give location) 402 North Main Street

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle)
c. (Last) RIEDLINGER

4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 28, 1899
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired) 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) South Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Riedlinger — BIRTHPLACE Russia
14. MOTHER'S MAIDEN NAME unknown Sigmund — BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. 519-14-3459
17. INFORMANT'S OWN SIGNATURE Otto Riedlinger — ADDRESS Paul, Idaho

4124

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adams - Stokes syndrome — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASCVD. — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1969, to 9-24-69, 19___, that I last saw the deceased alive on 9-11-69, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Ben K. Humphrey MD 253 (Degree or title)
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-29-69
24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery
24d. LOCATION (City, town, or county) (State) Paul, Idaho

DATE REC'D BY LOCAL REG. 10-3-69
REGISTRAR'S SIGNATURE Mary Ethel Carlson
25. EMBALMER Charles H Persons
LICENSE NO. E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4331
Local Reg. No. 22
Reg. Dist. No. 4-10

BIRTH NO.

RECEIVED
OCT 7 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 125
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paul (rural)
d. STREET ADDRESS (If rural, give location): Route # 2, Box 196

3. NAME OF DECEASED (Type or Print): a. (First) Starr; b. (Middle) Suzanne; c. (Last) Adams

4. DATE OF DEATH (Month) (Day) (Year): Sept. 25, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: March 22, 1953

9. AGE (In years last birthday): 16
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Kempton, Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Russell George Adams
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Florance Louise Bruner
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): — — —

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Russell G Adams
ADDRESS: Paul, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: one hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): automobile accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* 9-25, 19 69, *and that death occurred at* 9 45p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ben K. Humphreys 253 (Degree or title): MD
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 9-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Paul Cemetery
24d. LOCATION (City, town, or county) (State): Paul, Idaho

DATE REC'D BY LOCAL REG.: 10-3-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson

25. EMBALMER: Charles L Parsons
LICENSE NO.: E-494
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 16 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 27 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4332
Local Reg. No. 69
Reg. Dist. No. 452

BIRTH NO.

RECEIVED STATE OF IDAHO
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka 342 SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY IN (this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48 b. COUNTY: Yakima 525
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Yakima
d. STREET ADDRESS (If rural, give location): 1905 East Viola Street

3. NAME OF DECEASED (Type or Print): a. (First) Willie b. (Middle) Emmett c. (Last) Tibbetts

4. DATE OF DEATH (Month) (Day) (Year): Sept. 25, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 12, 1892

9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Mason (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Pawnee City Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wm. Mathus Tibbetts — BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Frances Mary Graves — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-05-2930

17. INFORMANT'S OWN SIGNATURE: Mrs Ora Mae Tibbetts — ADDRESS: Yakima, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-25-69 19__, *to* 9-25-69 19__, *that I last saw the deceased alive on* 9-25, 1969, *and that death occurred at* 2:40 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ken H. Humphrey 259 MD

23b. ADDRESS: Rupert Idaho

23c. DATE SIGNED: 9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: Sept. 26, 1969

24c. NAME OF CEMETERY OR CREMATORY: West Hills Mem. Park

24d. LOCATION (City, town, or county) (State): Yakima, Yakima Co. Wn.

DATE REC'D BY LOCAL REG.: 9-26-69

REGISTRAR'S SIGNATURE: Mary Ellen Carlson

25. EMBALMER: Charles H Parsons

LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK Ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4333
Local Reg. No. 929
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 1 51969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce (35)
b. CITY OR TOWN: Lewiston
LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho (13)
b. COUNTY: Nez Perce (35)
c. CITY OR TOWN: Lewiston
d. STREET ADDRESS (If rural, give location): Rt. 1, Box 337

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BERT	nmi	HENRIKSEN	1 September 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	17 April 1873	96				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (04)	Stock & Grain	Denmark	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
? Henriksen	Denmark	? Andersen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519 42 3077	George Henriksen	Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4133

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) HCVD
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Fx. Hip

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 1964, *to* Sept 1, 1969, *that I last saw the deceased alive on* Sept 1, 1969, *and that death occurred at* 5:05 PM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lus Brower (051) MD	1522-17th St, Lewiston	5 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	Burial 4 Sept 1969	Pendleton Cemetery	Pendleton, Umatilla Co., Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-1-69	Glenara Dalgen	R.H. Malcom R H Malcom	E-376

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4334
Local Reg. No. 236
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce (307)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce (350)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): Rt. 1, Box 386

3. NAME OF DECEASED (Type or Print): a. (First) VERNON; b. (Middle) CLAIRE; c. (Last) BROCK

4. DATE OF DEATH: (Month) (Day) (Year): 2 September 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 27 Nov. 1899

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dredge Opr. 09

10b. KIND OF BUSINESS OR INDUSTRY: Wash. Water Power Co.

11. BIRTHPLACE (State or foreign country): Grangeville, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dale Brock
BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Daisy Tipton
BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 05 2401

17. INFORMANT'S OWN SIGNATURE: Dorothy D. Jones
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Recent Coronary Occlusion

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒ XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug, 1967, *to* Sept, 1967, *that I last saw the deceased alive on* Sept, 1967, *and that death occurred at* 10:10PM m., *from the causes and on the date stated above.*

23a. SIGNATURE: R M Stover (507) MD (Degree or title)

23b. ADDRESS: 934 - Bryden Lewiston

23c. DATE SIGNED: 9/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 5 Sept 1969

24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-9-69

REGISTRAR'S SIGNATURE: Glenara Dalzell

25. EMBALMER: K. H. Malcom — K H Malcom

LICENSE NO.: E-376

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 26 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4335
Local Reg. No. 241
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 — SEP 22 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston — Bureau of Vital Statistics
c. LENGTH OF [illegible] (Hours): - 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1726 29th St. N.

3. NAME OF DECEASED (Type or Print)
a. (First): Walden Horn
b. (Middle):
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Sept. 2, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Sept. 11, 1906
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: general
11. BIRTHPLACE (State or foreign country): Sawyer, Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 52 4656
17. INFORMANT'S OWN SIGNATURE: V. Vassar — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic
DUE TO (c): Heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Sudden Death

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 1969, *to* Sept, 1969, *that I last saw the deceased alive on* _____, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. M. Stover, M.D. 507
23b. ADDRESS: LEWISTON, IDAHO
23c. DATE SIGNED: 9/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-16-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Stover

OCT 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4336
Local Reg. No. 243
Reg. Dist. No. 220

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): Orchards Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First): JOSEPH
b. (Middle): AARON
c. (Last): FRY

4. DATE OF DEATH (Month) (Day) (Year): 5 September 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 10 March 1875
9. AGE (In years last birthday): 94 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction 11
10b. KIND OF BUSINESS OR INDUSTRY: Roads
11. BIRTHPLACE (State or foreign country): Galena, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Volene Fry — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 01 5771
17. INFORMANT'S OWN SIGNATURE: X Alta L. Oxley — ADDRESS: Pinehurst, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Infirmities of age
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 62, *to* 9/5/69, 19____, *that I last saw the deceased alive on* 9/5/69, 19____, *and that death occurred at* 4:08AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John E. Carsson 083
23b. ADDRESS: 9th and Main Street, Lewiston, Idaho 83501
23c. DATE SIGNED: 9/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8 Sept 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-15-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO.: W E Black E-426

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 1 5 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4337
Local Reg. No. 239
Reg. Dist. No. 9-20

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1820 Grelle Ave.

3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) JAY c. (Last) HENDERSON

4. DATE OF DEATH (Month) (Day) (Year) 5 September 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 19 Dec. 1894

9. AGE (In years last birthday) 74 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carrier 08

10b. KIND OF BUSINESS OR INDUSTRY U. S. Postal Dept.

11. BIRTHPLACE (State or foreign country) Minneapolis, Minnesota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Henderson
BIRTHPLACE USA

14. MOTHER'S MAIDEN NAME Emma C. Carlson
BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) XXXXXXXXXX

16. SOCIAL SECURITY NO. 387 24 6239

17. INFORMANT'S OWN SIGNATURE x Mayme B. Henderson ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4918 Pneumonia (Pseudomonas) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Bronchitis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1968 *to* Sept, 1969, *that I last saw the deceased alive on* Sept, 1969, *and that death occurred at* 12:40AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Don Stover MD

23b. ADDRESS 939 Bryden Ave - Lew.

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8 Sept 1969

24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 9-11-69

REGISTRAR'S SIGNATURE Glenara Dalzen

25. EMBALMER W E Black

LICENSE NO. E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 17 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4338
Local Reg. No. 240
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nezperce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 3 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Reeds Nursing Home 335

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nezperce
d. STREET ADDRESS (If rural, give location): rural

3. NAME OF DECEASED (Type or Print)
a. (First): Marie
b. (Middle): Antoinette
c. (Last): Wissink

4. DATE OF DEATH (Month) Sept (Day) 6 (Year) 69

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Oct 22 1880
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Little Chute, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Henry Van Chen — BIRTHPLACE: Holland
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 48 1658
17. INFORMANT'S OWN SIGNATURE: Jas Wissink — ADDRESS: Nezperce, Idaho

18. CAUSE OF DEATH 3959
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): CALCIFIC AORTIC Stenosis — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/7, 62, *to* DATE, 19__, *that I last saw the deceased alive on* MARCH, 1962, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John V. Hamilton 013
23b. ADDRESS: 307 St John's Way
23c. DATE SIGNED: 9/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 9 1969
24c. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24d. LOCATION (City, town, or county): Nezperce (State): Idaho

DATE REC'D BY LOCAL REG.: 9-15-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: Clifford Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Crismon

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4339
Local Reg. No. 238
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE — SEP 15 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
c. LENGTH OF STAY (in this place): 35
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Asotin 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 1029 Benjamin

3. NAME OF DECEASED (Type or Print)
a. (First): LYLA
b. (Middle): LEE
c. (Last): OEDEWALDT

4. DATE OF DEATH (Month) (Day) (Year): 9 7 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 6, 1923
9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Cando, No. Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Elbert R. Rawdon — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Stella M. Martin — BIRTHPLACE: So. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 516-18-7149
17. INFORMANT'S OWN SIGNATURE: Rolland Oedewaldt — ADDRESS: 1029 Benjamin, Clk

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of The Breast

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 20, 1968, *to* 9 6, 1969, *that I last saw the deceased alive on* 9 6, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 114
23b. ADDRESS: St John Way
23c. DATE SIGNED: 9 9 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Sept. 10, 1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 9-10-69
REGISTRAR'S SIGNATURE: Glenard Walzen
25. EMBALMER: WC Merchant
LICENSE NO.: FD5

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4340
Local Reg. No. 244
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 SEP 22 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (If outside place): 26 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 2840 - 7th Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First): CLYDE
b. (Middle): HARMON
c. (Last): LOVELACE

4. DATE OF DEATH (Month) (Day) (Year): 9 Sept 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 17 July 1895
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Heavy Equipment
11. BIRTHPLACE (State or foreign country): Parker, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cullin Lovelace — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Lillian Manners — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW-1 — (If yes, give war or dates of service): 3
16. SOCIAL SECURITY NO.: 517 05 0562
17. INFORMANT'S OWN SIGNATURE: Cora Lovelace — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Coronary arteriosclerosis — 10 yrs
DUE TO (c): and atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1957, 19__, *to* 1969, 19__, *that I last saw the deceased alive on* 8 Sept, 1969, *and that death occurred at* 3:35 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Walter W Seely 757
23b. ADDRESS: 619 Drag. Clarkston Wash
23c. DATE SIGNED: 11 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12 Sept 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-15-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 22 1969

FEB 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4341
Local Reg. No. 242
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35 SEP 22 1969
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 825-10th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) W
b. (Middle) MARK
c. (Last) MACE

4. DATE OF DEATH (Month) (Day) (Year) Sept. 10, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH June 22, 1902
9. AGE (In years last birthday) 67 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Dealer 22
10b. KIND OF BUSINESS OR INDUSTRY Retail
11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME W. J. Mace
BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Anna Morrow
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 533 01 2254A
17. INFORMANT'S OWN SIGNATURE X Mrs W. Mark Mace ADDRESS Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 5-6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Periarteritis Nodosa. — 6 mo.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1969, to Sept 8, 1969, that I last saw the deceased alive on Sept 9, 1969, and that death occurred at 1½ a m., from the causes and on the date stated above.

23a. SIGNATURE B R Stern (Degree or title) M D
23b. ADDRESS Lewiston Idaho
23c. DATE SIGNED 15 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Sept. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY Normal Hill
24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 9-16-69
REGISTRAR'S SIGNATURE Glenard Walzer
25. EMBALMER V. Vassar
LICENSE NO. E297

FIRM NAME Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4342
Local Reg. No. 346
Reg. Dist. No. 220

BIRTH NO.

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nelsons Nursimg Home 129

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1139 Bryden

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) W. c. (Last) WOLFE

4. DATE OF DEATH (Month) (Day) (Year) Sept. 10, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH April 10, 1879

9. AGE (In years last birthday) 90
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Agent 24

10b. KIND OF BUSINESS OR INDUSTRY Land Selesman

11. BIRTHPLACE (State or foreign country) Pullman, Washington

12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME William M. Wolfe
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Not Available
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE
ADDRESS Troy, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis / 3 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Infirmities of age.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1968, *to* Sept, 1969, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] M.D.

23b. ADDRESS 939 Bryden ave. LEWISTON, IDA

23c. DATE SIGNED 9-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 9/13/1969

24c. NAME OF CEMETERY OR CREMATORY Vineland Cemetery

24d. LOCATION (City, town, or county) Clarkston, Washington (State)

DATE REC'D BY LOCAL REG. 9-18-69

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER [signature]

LICENSE NO. FD 5

FIRM NAME: MC Merchant

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

BIRTH NO. 69-9551

RECEIVED STATE OF IDAHO

State File No. 4343
Local Reg. No. 249
Reg. Dist. No. 220

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 — SEP 22 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston — Bureau of Vital Statistics
c. LENGTH OF STAY (If in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3225 - 8th Street E

3. NAME OF DECEASED (Type or Print)
a. (First): WARREN
b. (Middle): ASHLEY
c. (Last): GREENE

4. DATE OF DEATH (Month) (Day) (Year): 12 Sept 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 9 Sept 1969
9. AGE (In years last birthday): - - - -
IF UNDER 1 YEAR: Months - - Days 2
IF UNDER 24 HRS.: Hours 21 Min. 49

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dorsey Greene — BIRTHPLACE: Oneida, Tenn.
14. MOTHER'S MAIDEN NAME: Elsie Rose Brown — BIRTHPLACE: Cottage Grove, Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Dorsey Greene — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

486X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-9, 1969, *to* 9-11, 1969, *that I last saw the deceased alive on* 9-11, 1969, *and that death occurred at* 7:50 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. S. [signature] 160
23b. ADDRESS: 307 St John's Way, Lewiston, Idaho
23c. DATE SIGNED: 9-17-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 13 Sept 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-19-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO. E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4344
Local Reg. No. 247
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 360 — SEP 2 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics — yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
d. STREET ADDRESS (If rural, give location): rural

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DOUGLAS	ALFRED	CHRISTENSEN, Jr.	13 September 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Male	White	Married	2 March 1931	38				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher 12	Education	Seattle, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Douglas A. Christensen, Sr.	SLC, Utah	Hannah I. Snowling	SLC, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean 6	518 36 8750	Patricia L. Christensen	Kendrick, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1530

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cecum c

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) metastisis, liver, mesentery & omentum
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb 1969	Carcinoma of cecum & metastases	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb, 1969, *to* Sept 13, 1969, *that I last saw the deceased alive on* Sept 13, 1969, *and that death occurred at* 10:30 PM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D.A. Christensen 091 MD	Kendrick, Idaho	9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	16 Sept 1969	Kendrick Cemetery	Kendrick, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-18-69	Glenara Dalzen	K H Malcom	E-376

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4345
Local Reg. No. 248
Reg. Dist. No. 220

BIRTH NO.

RECEIVED Bureau of Vital Statistics SEP 22 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY IN (this place): 3 WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor Nursing Home 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 502 Bryden Drive

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) COLBERT c. (Last) RICHARDSON

4. DATE OF DEATH (Month) (Day) (Year): 13 September 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 19 February 1882

9. AGE (In years last birthday): 87 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Stock & Grain

11. BIRTHPLACE (State or foreign country): Moberly, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William A. Richardson — BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Miranda Holbrook — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 42 3890

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 16, 1966 *to* Sept 13, 1969, *that I last saw the deceased alive on* Sept 12, 1969, *and that death occurred at* 1:55 AM, *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 013 (Degree or title) MD

23b. ADDRESS: Lewiston Idaho

23c. DATE SIGNED: 9/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 16 Sept 1969

24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-18-69

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature] W E Black — LICENSE NO.: E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4346
Local Reg. No. 245
Reg. Dist. No. 220

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 351 SEP 22 1969
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY IN CITY
d. FULL NAME OF HOSPITAL OR INSTITUTION St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1708 - 18th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	AGNES	LUELLA	SERLE	14 Sept. 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	31 Jan 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Walla Walla, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George C. Macomb	Arkansas	Zora A. Harris	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	535 01 7913	A M. Serle	Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Metastatic Carcinoma of Endometrium — 2 years

DUE TO (c) Carcinoma of Endometrium — 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Incontinence — 3 weeks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 27 1969 *to* 9-14, 1969, *that I last saw the deceased alive on* 9-14, 1969, *and that death occurred at* 11:30 AM *m. from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
A P Johnson, 181 M D	Lewiston, Idaho	9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	Burial 18 Sept 1969	Mountain View Cemetery	Walla Walla, Walla Walla Co., Wn.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-15-69	Elmara Dalgen	W E Black	E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4347
Local Reg. No. 250
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 35 SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
Bureau of Vital Statistics
LENGTH OF STAY (In this place): 19days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3223-5th St

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

3. NAME OF DECEASED (Type or Print): a. (First) Arthur; b. (Middle); c. (Last) Elben

4. DATE OF DEATH: (Month) (Day) (Year) Sep 15, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 13, 1902

9. AGE (In years last birthday): 67
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 28

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Weippe, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Sam Elben
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Bertha Van Artsdalen
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-12-3156A

17. INFORMANT'S OWN SIGNATURE: X Mrs Marvel Elben
ADDRESS: Lewiston, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) severe emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-26-69, *19*__, *to* 9-15, *19* 69, *that I last saw the deceased alive on* 9-15-, *19* 69, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept, 18, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 9-24-69
REGISTRAR'S SIGNATURE: Glenda Nelson
25. EMBALMER: V. Vasser
LICENSE NO.: E 299

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4348
Local Reg. No. 253
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nezperce 35' SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Bureau of Vital Statistics
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Nelson Nursing Home 129

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Craigmont
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Joseph
b. (Middle):
c. (Last): Berg

4. DATE OF DEATH (Month) (Day) (Year): Sept. 17 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: May 18 1874
9. AGE (In years last birthday): 95 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer, retired 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Hyde Park Minn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thaddus Berg — BIRTHPLACE: Wittenburg, Germany
14. MOTHER'S MAIDEN NAME: Elizabeth Fix, — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 58 0758 J 1
17. INFORMANT'S OWN SIGNATURE: Charles B. Hoagen — ADDRESS: Grangeville Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-12, 1969, *to* 9-17, 1969, *that I last saw the deceased alive on* 9-14, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard M. Alford MD 794
23b. ADDRESS: 1522 17th St, Lewiston
23c. DATE SIGNED: 9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 20 1969
24c. NAME OF CEMETERY OR CREMATORY: I O O F Cemetery
24d. LOCATION (City, town, or county) (State): Craigmont, Idaho

DATE REC'D BY LOCAL REG.: 9-24-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: Clifford Uhlorn
LICENSE NO.: E 10

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Uhlorn Funeral Home.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 28 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4349
Local Reg. No. 254
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 35 OCT 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
Bureau of Vital Statistics
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. JOSEPHS HOSPITAL 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: NEZ PERCE 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
d. STREET ADDRESS (If rural, give location): 1529 Lewis Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VIOLA	LATRELL	MACKEY	Sept. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	Dec. 10, 1919	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homekeeper 01	Home	Kansas, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Cecil Lale	Arkansas	Nettie Marie Oday	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Unknown	Jack Mackey	1529 Lewis Ave. Lew.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1991 Adeno Carcinoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* 9/20, 1969, *that I last saw the deceased alive on* 9/20, 1969, *and that death occurred at* 10:35 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John E. Carsonyn. MD		9/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 23, 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-29-69	Alexander Dalzen	W.C. Merchant	FD 5

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Merchant Funeral Home

DUTIES:

OCT 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 26 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 20 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4350
Local Reg. No. 257
Reg. Dist. No. 220

RECEIVED
SEP 29 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN Lewiston Orchards
LENGTH OF STAY (in this place) 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION Lewiston Manor 318

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 1712-10th Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Charles	J	Rodgers	Sept. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	August 30, 1887	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Conductor 10	Railroad	Wilton Junction, Iowa	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Matthew Rodgers	Iowa	Mary Doudel	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no record	C A Rodgers	Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 2 yrs
DUE TO (c) Carcinoma of Lung — 4 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hemorrhoids Untreated — 2 yrs

1621

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1969, to Sept 22, 1969, *that I last saw the deceased alive on* Sept 10, 1969, *and that death occurred at* 4:01 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Frank E Baldock MD		1522 17th St	9/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9/23/69	Lewis-Clark Memorial Garden	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-24-69	Glenna Walgen	Vassar	E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4351
Local Reg. No. 252
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 SEP 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (If this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 615

3. NAME OF DECEASED (Type or Print)
a. (First): Leo
b. (Middle): Bert
c. (Last): Rhimer

4. DATE OF DEATH (Month) (Day) (Year): Sept 22, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 28, 1910
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager 26
10b. KIND OF BUSINESS OR INDUSTRY: Apartment house
11. BIRTHPLACE (State or foreign country): Colfax, Washington
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Otto Rhimer — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Sophia Hendriksen — BIRTHPLACE: Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW II-Korean war
16. SOCIAL SECURITY NO.: no record
17. INFORMANT'S OWN SIGNATURE: X Gloria M. Rhimer — ADDRESS: Lewiston, Idaho

1621

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Carcinoma Lung — 2 months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 14, 1969, *to* Sept 22, 1969 *that I last saw the deceased alive on* Sept 22, 1969, *and that death occurred at* 4 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 220
23b. ADDRESS: 625 [illegible] Lewiston Ida
23c. DATE SIGNED: 9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9/24/69
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memorial
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-24-69
REGISTRAR'S SIGNATURE: Glenara Dolzen
25. EMBALMER: V. Vassar — LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4352
Local Reg. No. 266
Reg. Dist. No. 220

BIRTH NO.

RECEIVED OCT 20 1969

1. PLACE OF DEATH
a. COUNTY: Nezperce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Lewiston Burial
c. LENGTH OF STAY (in this place): Hr'S
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 35-2
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 513 North State Street

3. NAME OF DECEASED (Type or Print): a. (First) THOMAS b. (Middle) FRANKLIN c. (Last) HEATH

4. DATE OF DEATH: (Month) (Day) (Year) September 24, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 15, 1893

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Millworker 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Joplin Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank E Heath — BIRTHPLACE: Joplin Missouri

14. MOTHER'S MAIDEN NAME: Annie Kirk — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 18 8157

17. INFORMANT'S OWN SIGNATURE: Vernice R Heath — ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) METABOLIC ACIDOCIS. — 2 w.
DUE TO (c) CARCINOMA LUNG. — Unk.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9/24/69

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/23, 19 69 *to* 9/24, 1969, *that I last saw the deceased alive on* 9/24, 19 69, *and that death occurred at* 11:40a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 874

23b. ADDRESS: 628 - 5th Avenue Lewiston, Ida.

23c. DATE SIGNED: 9/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/27/69

24c. NAME OF CEMETERY OR CREMATORY: Ioof Cemetery

24d. LOCATION (City, town, or county) (State): Craigmont, Idaho

DATE REC'D BY LOCAL REG.: 10-10-69

REGISTRAR'S SIGNATURE: Glenna Walzer

25. EMBALMER: Robert Hansen [signature] — LICENSE NO.: E 433

FIRM NAME: Hansen funeral home

Federal Security Agency
United States Public Health Service

Form DH-63021

Thanks

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 3 1979

JUN 25 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4353
Local Reg. No. 257
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35 OCT 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 212 - 5th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DALLAS	nmi	CLARK	25 Sept 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	10 Apr 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rural Carrier 28	U.S. Postal Dept.	Decatur, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Clark	Illinois	Laura E. Roney	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 40 3055	Earl W. Clark	Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Heart Failure	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Pulm Fibrosis + Emphysema	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Carcinoma of Prostate	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/18, 19 52, *to* 9/25, 19 69, *that I last saw the deceased alive on* 9/25, 19 69, *and that death occurred at* 9:30pm *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
114 MD	[illegible] Lewiston	9/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	27 Sept 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-1-69	Glenna Dalgon	W E Black	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

FEB 19 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4354
Local Reg. No. 259
Reg. Dist. No. 220

Certificate of Death

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 23 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 0216 - 26th Street

3. NAME OF DECEASED (Type or Print)
a. (First): LELIA
b. (Middle): GENEVA
c. (Last): O'BRIEN

4. DATE OF DEATH (Month) (Day) (Year): 27 Sept 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 26 Jan 1902
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Bottineau, N.D.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward Jacques — BIRTHPLACE: Mich.
14. MOTHER'S MAIDEN NAME: Lea Pare — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 538 05 2897
17. INFORMANT'S OWN SIGNATURE: Marie Anderson — ADDRESS: Lewiston, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart disease — years
DUE TO (c): Diabetes Mellitus — years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Cerebrovascular Accident — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4, 1969, *to* 9-27, 1969, *that I last saw the deceased alive on* 9-26, 1969, *and that death occurred at* 4:25 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 781 M.D.
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 10-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 30 Sept 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-6-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: K. H. Malcom — K H Malcom
LICENSE NO.: E-376

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4355
Local Reg. No. 257
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 OCT 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 2106 Birch Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): THEODORE
b. (Middle): NMI
c. (Last): COOPER

4. DATE OF DEATH (Month) (Day) (Year): 28 Sept 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12 May 1895
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumbering
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Cooper — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Jane Rathbone — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no record
17. INFORMANT'S OWN SIGNATURE: Leona Cooper — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: monents

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Coronary artery disease — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* - - - - - - , 19 - - , *to* - - - - - - , 19 - - , *that I last saw the deceased alive on* - - - - - - , 19 - - , *and that death occurred at* 9:30 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Ducloz 583 (Degree or title): Coroner
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 30 Sept 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2 Oct 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-1-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 2 1 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4356
Local Reg. No. 258
Reg. Dist. No. 320

RECEIVED

Certificate of Death

STATE OF IDAHO

OCT 6 1969

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nezperce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) one month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) 206 South B Street

3. NAME OF DECEASED (Type or Print) a. (First) MINNIE b. (Middle) M. (Vaughan) c. (Last) WILSON

4. DATE OF DEATH (Month) (Day) (Year) Sept 29, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 19, 1892

9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Grangeville, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Orren Bentley BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Bidsey Johnson BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-36-4910

17. INFORMANT'S OWN SIGNATURE Clyde Wilson RH ADDRESS Grangeville, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 2 to 3 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 9-22-69

19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma Rectum

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-29, 1969, to 9-29, 1969, that I last saw the deceased alive on 9-29, 1969, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE John P. Barney M.D 028 (Degree or title)

23b. ADDRESS 347 5th Lewiston, Idaho

23c. DATE SIGNED 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/1/69

24c. NAME OF CEMETERY OR CREMATORY Prairieview

24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. 10-3-69

REGISTRAR'S SIGNATURE Glenna Dalzell

25. EMBALMER Robert R Hansen

LICENSE NO. E 433

FIRM NAME: Hansen Funeral Home

Barnes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4357
Local Reg. No. 265
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
OCT 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: NezPerce 350	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho b. COUNTY: NezPerce 350
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Culdesac c. LENGTH OF STAY (in this place):	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Culdesac
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): home 000	d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First): Cecil	b. (Middle): Elmo	c. (Last): Hart	4. DATE OF DEATH (Month) Sept. (Day) 30 (Year) 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married	8. DATE OF BIRTH: Jan, 29, 1909	9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Pataha, Washington	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Hart	BIRTHPLACE: NoRecord	14. MOTHER'S MAIDEN NAME: Ella Dell Brower	BIRTHPLACE: DesMoines, Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.11	16. SOCIAL SECURITY NO.: 518-12-2438	17. INFORMANT'S OWN SIGNATURE: Doris Muriel Bateman	ADDRESS: Culdesac, Idaho.	

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Arrest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Poss. Emphysema
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify): XX	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* XXX, *19*___, *to* XXX, *19*___, *that I last saw the deceased alive on* XX, *19*___, *and that death occurred at* 8:30PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duclos 583	(Degree or title): Coroner	23b. ADDRESS: Lewiston, Idaho	23c. DATE SIGNED: 10/9/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 10-3-1969	24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery	24d. LOCATION (City, town, or county) (State): Clarkston, Wash.
DATE REC'D BY LOCAL REG.: 10-10-69	REGISTRAR'S SIGNATURE: Glenora Walzen	25. EMBALMER: V Vassar	LICENSE NO.: E 297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 21 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4358
Local Reg. No. 77
Reg. Dist. No. 530

Certificate of Death

RECEIVED
SEP 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Oneida 36a
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad
c. LENGTH OF STAY (In this place): 3 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oneida Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Oneida 36
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - St. John
d. STREET ADDRESS (If rural, give location): RFD # 1, Malad, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): NELLIE
b. (Middle): DESCHAMPS
c. (Last): THOMAS

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1969

5. SEX: Fe.
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: December 8, 1886
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): St. John, Oneida Co., Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Deschamps — BIRTHPLACE: Quebec, Canada
14. MOTHER'S MAIDEN NAME: Ann Stephense — BIRTHPLACE: Carmarthenshire, Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: x Morris Thomas Jr — ADDRESS: RFD # 1 Malad, Idaho

4418

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Dissecting aortic Aneurysm (Abdominal) — INTERVAL BETWEEN ONSET AND DEATH: @ 2 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerotic vascular disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 5, 1969 *to* Sept 5, 1969, *that I last saw the deceased alive on* Sept 5, 1969, *and that death occurred at* 0545 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John A. Jones 899 MD
23b. ADDRESS: Malad Idaho
23c. DATE SIGNED: 9.10.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: St. John Cemetery
24d. LOCATION (City, town, or county) (State): Oneida County, Idaho

DATE REC'D BY LOCAL REG.: Sept 15. 1969
REGISTRAR'S SIGNATURE: Ruth G. Sweeten
25. EMBALMER: Rupert H. Benson
LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: BENSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4359
Local Reg. No. 18
Reg. Dist. No. 530

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 1 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Oneida 360
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Oxford Mountain
LENGTH OF STAY (in this place) 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ---

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Oneida 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RFD # 1 Malad City, Idaho
d. STREET ADDRESS (If rural, give location) ---

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RALPH	WILLIAM	HARDING	September 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	married	July 10, 1902	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
High School coach	education	Malad City, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ralph J. Harding	Willard, Utah	Martha Williams	Malad, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-26-1798	Don L. Harding	2952 Birchdale Ct. Woodbridge Va. 22191

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) crushing injuries to chest with severe hemorrhages, internally — INTERVAL BETWEEN ONSET AND DEATH: immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) probable skull fracture — immed.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	mountain slope	(West face of Oxford Mountain.) Oneida 360 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR
Sept. 25, 1969 10 a.m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	horse fell and rolled over him

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* approx 10: A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byford H. Benson	583 Coroner	Malad Idaho	Sept. 26, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 29, 1969	Malad City Cemetery	Malad City, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29-1969	Ruth D. Sweeten	Byford H. Benson	E-351

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: BENSON FUNERAL HOME

DUTIES:

OCT 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 10 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 26 1986

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Dr. Hoffe

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4360
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Owyhee 370 SEP 18 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Homedale
c. LENGTH OF STAY (at this place) 6 Wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homedale Nursing Home 305

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) W. c. (Last) Stoskopf

4. DATE OF DEATH (Month) Sept. (Day) 9 (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan. 9, 1882

9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Cleveland, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Moos — BIRTHPLACE Luxemburg, Germany

14. MOTHER'S MAIDEN NAME Caroline Hartzman — BIRTHPLACE Frensdorf, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. — (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 558-74-7041

17. INFORMANT'S OWN SIGNATURE x Edna M. Willcuts — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4-109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 15, 1969 *to* Sept 9, 1969, *that I last saw the deceased alive on* Sept 2, 1969, *and that death occurred at* 1 a m., *from the causes and on the date stated above.*

23a. SIGNATURE 570 MD (Degree or title)

23b. ADDRESS Caldwell Ida

23c. DATE SIGNED 9-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 12, 69

24c. NAME OF CEMETERY OR CREMATORY Beaver Cemetery

24d. LOCATION (City, town, or county) Beaver, Kansas (State)

DATE REC'D BY LOCAL REG. Sept. 9 1969

REGISTRAR'S SIGNATURE Andrew Warfield

25. EMBALMER Lloyd M. Flahiff — LICENSE NO. E293

FIRM NAME Homedale's Flahiff Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 0 1998

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4361
Local Reg. No. 392
Reg. Dist. No.

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 22 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Marsing
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 11 Mi. S. of Marsing 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
d. STREET ADDRESS (If rural, give location): Route # 6

3. NAME OF DECEASED (Type or Print)
a. (First): Lanny
b. (Middle): R.
c. (Last): Blattner

4. DATE OF DEATH (Month) (Day) (Year): Sept. 11, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 26, 1942
9. AGE (In years last birthday): 27 — IF UNDER 1 YEAR: Months 0, Days 15 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): State Hiway Dept.
10b. KIND OF BUSINESS OR INDUSTRY: State of Idaho
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: D. A. Blattner — BIRTHPLACE: Kuna, Idaho
14. MOTHER'S MAIDEN NAME: Margaret Pride — BIRTHPLACE: Nampa, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1960-1965 7
16. SOCIAL SECURITY NO.: 519-48-2406
17. INFORMANT'S OWN SIGNATURE: X Marcia K. Blattner — ADDRESS:

8169

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Head Injury — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Contusion of Left Lung
DUE TO (c) Rib fractures - left 7-8 & 9th ribs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Sept. 12 '69
19b. MAJOR FINDINGS OF OPERATION: Massive head injury with extension of Cranial Contents
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.): Highway 95 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Marsing 370 Owyhee Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 11, 1969 12:15 P.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Turned over highway loader as rounding curve

22. *I hereby certify that I ~~attended the deceased from~~ investigated, 19 only, ~~to~~ 9-11, 1969, that I ~~last saw the deceased~~ did not see alive on Sept 11, 1969, and that death occurred at 12:00 P.m., from the causes and on the date stated above.*

23a. SIGNATURE: Andrew Warfield 583 4 (Degree or title): Coroner
23b. ADDRESS: Box 366 Homedale, Ida
23c. DATE SIGNED: 9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-15-1969
24c. NAME OF CEMETERY OR CREMATORY: Middleton Cemetery
24d. LOCATION (City, town, or county) (State): Middleton, Idaho

DATE REC'D BY LOCAL REG.: Sept. 11 '69
REGISTRAR'S SIGNATURE: Andrew Warfield
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 25 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 17 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 02 2000

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4362
Local Reg. No. 141
Reg. Dist. No. 330

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): Star Route SE of City

3. NAME OF DECEASED (Type or Print)
a. (First): ALBERTA
b. (Middle): GRACE
c. (Last): MORDHORST

4. DATE OF DEATH (Month) (Day) (Year): September 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 3, 1911
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Sterling, Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas J. Lukehart — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Ida Belle Dee — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Bill A. Mordhorst — ADDRESS: Grangeville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Generalized carcinomatosis	4 mo
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Undifferentiated bronchogenic carcinoma rt lung	1 yr
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 68, *19*__, *to* Sept 11, *19*69, *that I last saw the deceased alive on* Sept 9, *19*69, *and that death occurred at* 3:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas W Watt Jr M.D. 553
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 9/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: 9-18-69
REGISTRAR'S SIGNATURE: Annabel Anderson
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
SEP 24 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4363
Local Reg. No. 142
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitland (Rural)
c. LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6 Mi. SE of City 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Minnesota 24
b. COUNTY Ramsey 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Paul
d. STREET ADDRESS (If rural, give location) 743 Laurel Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	THEOFILUS	BUDZISZEWSKI	September 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	December 21, 1929	39	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mail Carrier 08	Post Office	Marshall Cy, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Anton Budziszewski	Illinois	Mary Gratzek	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- -	476-40-8897	Ludwina Budziszewski	St. Paul, Minn.

8129

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Fractured Cervical Vertebra — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Accident	Highway 06	Fruitland 380 Payette Idaho	9 - 18-1969 11:40 A.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Automobile & Truck collision

22. *I hereby certify that I ~~attended the deceased from~~ Investigated, ~~xxxx

DUTIES:

SEP 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 2 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4364
Local Reg. No. 143
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 26 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY PAYETTE 380
b. CITY OR TOWN Mile N of Payette
LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mile N of Payette 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 617 E. Court

3. NAME OF DECEASED (Type or Print)
a. (First) RUSSELL
b. (Middle) MELVIN
c. (Last) CASSIDY

4. DATE OF DEATH (Month) (Day) (Year) Sept. 22 1969

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Oct. 8 1946 10/8/46
9. AGE (In years last birthday) 22 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Recapper 06
10b. KIND OF BUSINESS OR INDUSTRY OK Rubber Plant
11. BIRTHPLACE (State or foreign country) Santa Maria, California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Herbert G. Cassidy — BIRTHPLACE --
14. MOTHER'S MAIDEN NAME Vera McHenry — BIRTHPLACE --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-52-7498
17. INFORMANT'S OWN SIGNATURE Herbert G. Cassidy — ADDRESS Weiser, Ida.

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) AUTO ACCIDENT brain concussion — INTERVAL BETWEEN ONSET AND DEATH instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE / (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13380
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigated *to* September 22, 1969, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Hardy H Harkam 583 (Degree or title) Coroner
23b. ADDRESS Payette Idaho.
23c. DATE SIGNED Sept. 22 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Sept. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser, Idaho (State)

DATE REC'D BY LOCAL REG. 9-25-1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER [signature] — LICENSE NO. E318

FIRM NAME: CHAPEL of the ROSES Payette

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 8 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 2 9 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4365
Local Reg. No. 144
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 26 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 2109 6th Ave. So.

3. NAME OF DECEASED (Type or Print)
a. (First) Gustav
b. (Middle) William
c. (Last) Debban

4. DATE OF DEATH (Month) Sept. (Day) 22 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 14, 1886
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Green, Iowa
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Debban — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Amelia (unknown) — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-01-3423
17. INFORMANT'S OWN SIGNATURE: Melvin F. Debban — ADDRESS: 2109 6th Ave So Payette

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

185X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Metastatic carcinoma — 1 yr.
DUE TO (c) Carcinoma of prostate — 1 yr.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Cholecystectomy because of Cholecystitis — 3 wks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. *, 1968, to* Sept 22 *, 1969, that I last saw the deceased alive on* Sept 22 *, 1969, and that death occurred at* 4:00 P.m. *, from the causes and on the date stated above.*

23a. SIGNATURE: E. Glasnoll, M.D. 082 (Degree or title)
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 9/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: SEPT. 25/69
24c. NAME OF CEMETERY OR CREMATORY: Parkview Cemetery
24d. LOCATION (City, town, or county) (State): New Plymouth Payette Idaho

DATE REC'D BY LOCAL REG.: 9-25-69
REGISTRAR'S SIGNATURE: Annabel Anderson
25. EMBALMER: Milford D. Dragoo
LICENSE NO.: E318

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Chapel of the Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4366
Local Reg. No. 146
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Payette (380) — OCT 9 1969 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette — STAY (in this place): 1 Month — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Conv. Center (355)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Payette (380) — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth — d. STREET ADDRESS (If rural, give location): 307 E. Elm St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	TONY	(NMN)	JIM	September 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Oct. 31, 1884	84	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Section Hand (c)	Railroad	Turkey	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	A-666488	Edgar F. Jim	Caldwell, Idaho

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic cerebral arteriosclerosis and basilar thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Chronic arteriosclerotic heart disease with decompensation — 10 yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic hypertrophic prostatitis — 5 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 26, 1969, *to* Sept. 30, 1969, *that I last saw the deceased alive on* Sept. 29, 1969, *and that death occurred at* 12:20 AM, *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lee E. Davis, (31)	M.D.	New Plymouth, Idaho	Oct. 2/1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 2, 1969	Park View Cemetery	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-8-69	Dorothy Anderson	Faith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 25 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4367
Local Reg. No. 9
Reg. Dist. No. 500-602

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Power 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place): 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: Weber 553
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ogden
d. STREET ADDRESS (If rural, give location): 536 East 1700 North

3. NAME OF DECEASED (Type or Print)
a. (First): MARIA
b. (Middle): MAY
c. (Last): GARNER

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 13, 1969

5. SEX: Female

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 1, 1882

9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months: 5 Days: 12
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Ogden, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James H. Roylance
BIRTHPLACE: Burlington, Iowa

14. MOTHER'S MAIDEN NAME: Georgina Barnett
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-22-7925

17. INFORMANT'S OWN SIGNATURE: James Garner
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1969, *to* Sept 15, 1969, *that I last saw the deceased alive on* Sept 13, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. A. Hunt 255 MD
23b. ADDRESS: American Falls, Ida
23c. DATE SIGNED: 9-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9-13-69
24c. NAME OF CEMETERY OR CREMATORY: North Ogden Cemetery
24d. LOCATION (City, town, or county) (State): Ogden, Utah

DATE REC'D BY LOCAL REG.: Sept 19 1969
REGISTRAR'S SIGNATURE: Irene Deeg

25. EMBALMER: H. L. Davis
LICENSE NO.: E-253
FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 20 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4368
Local Reg. No. 8
Reg. Dist. No. 500-602

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) GILBERT
b. (Middle) RUSSELL
c. (Last) PIERSON

4. DATE OF DEATH (Month) (Day) (Year) Sept. 13, 1969

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug. 8, 1902
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR: Months 1, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 11
10b. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (State or foreign country) Plymouth, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hemon W. Pierson — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Janet Archibald, — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-09-6212
17. INFORMANT'S OWN SIGNATURE Alta Pierson — ADDRESS Aberdeen, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

428X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Marked cardiac decompensation	3 wks
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Valvular incompenentcy	5 years
DUE TO (c)	Chronic myocarditis	8 years
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Chronic renal failure	2 Months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 7, 1950, *to* Sep. 13, 1969, *that I last saw the deceased alive on* Sep. 12, 1969, *and that death occurred at* 6:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE F. L. Harms 203 (Degree or title) MD
23b. ADDRESS American Falls, Idaho
23c. DATE SIGNED 15 Sep. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial
24b. DATE 9-16-69
24c. NAME OF CEMETERY OR CREMATORY Aberdeen Cemetery
24d. LOCATION (City, town, or county) (State) Aberdeen, Idaho

DATE REC'D BY LOCAL REG. Sept. 19, 1969
REGISTRAR'S SIGNATURE Irene Deeg
25. EMBALMER H. L. Davis — LICENSE NO. E-253
FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4369
Local Reg. No. 10
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power SEP 25 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL) American Falls
c. LENGTH OF STAY (in this place) 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sterling (Rural)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
FRANK	B.	BUFFI	Sept.	14,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Never married	Feb. 22, 1908	61	6	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Butte, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Barney G. Buffi	Italy	Louise Regona	France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-10-8330	Jane Buffi	Sterling, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5400

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Peritonitis	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Ruptured appendix	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Sept 1, 1969, to 9-14, 1969, that I last saw the deceased alive on 9-14, 1969, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
255 T. A. Hunt MD	American Falls	9-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	9-18-69	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-23-69	Irene Dilley	H. L. Davis	E-253

FIRM NAME Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4370
Local Reg. No. 11
Reg. Dist. No. 500-602

Certificate of Death

BIRTH NO. 69-9587 RECEIVED STATE OF IDAHO

SEP 25 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) VICTOR b. (Middle) c. (Last) LOZANO, JR.

4. DATE OF DEATH (Month) (Day) (Year): Sept. 16, 1969

5. SEX: Male

6. COLOR OR RACE: Mex.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant

8. DATE OF BIRTH: Sept. 15, 1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days: 1 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): American Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Victor Lozano — BIRTHPLACE: Mexico

14. MOTHER'S MAIDEN NAME: Olga Pena — BIRTHPLACE: Am. Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Victor M Lozano ADDRESS: Aberdeen, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-15, 1969, *to* 9-16, 1969, *that I last saw the deceased alive on* 9-16, 1969, *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 255 T. H. Hunt MD

23b. ADDRESS: American Falls, Ida

23c. DATE SIGNED: 9-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. &Burial

24b. DATE: 9-18-69

24c. NAME OF CEMETERY OR CREMATORY: Aberdeen Cemetery

24d. LOCATION (City, town, or county) (State): Aberdeen, Idaho

DATE REC'D BY LOCAL REG.: 9-23-69

REGISTRAR'S SIGNATURE: Irene Deeg

25. EMBALMER: Bud Kelly Bud Kelly

LICENSE NO.: E-467

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4371
Local Reg. No. 12
Reg. Dist. No. 500-602

RECEIVED
SEP 29 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PARLEY		RUSHFORTH	Sept. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Married	Aug. 22, 1888	81	0	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 64	Farm	Kaysville, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James B. Rushforth	Utah	Phoebe Merrill	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	519-40-4863	X Verda Rushforth	Am. Falls, Ida.

4789

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute coronary occlusion	10 minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Chronic coronary occlusion	3 years
DUE TO (c)	Mild cardiac decompensation	1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	none	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 19, 19 49, *to* Sept. 19, 1969, *that I last saw the deceased alive on* Sept 19, 1960, *and that death occurred at* 5:58 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. E. Harris MD M.D.	213 Idaho Street, American Falls, Idaho	9-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-23-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 27, 1969	Irene Deeg	W. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 22 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 10 1969 Bureau of Vital Statistics

State File No. 4372
Local Reg. No. 971
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 126 Hayes St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location): 126 Hayes St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLARD	AGUSTUS	THOMPSON	Sept. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Widowed	Oct. 8, 1889	79	11	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber 21	Barber Shop	Rockland, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Thompson	Utah	Emily M. Allen	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-36-5396	Willard Thompson	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4419

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Ruptured Aortic Aneurysm	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			9-26 m.		

22. *I hereby certify that I attended the deceased from* 8-15, 19 69, *to* 9-26-69, *that I last saw the deceased alive on* [redacted], 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
255 T. A. Hunt MD	American Falls Idaho	10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-29-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
October 6, 1969	Irene Deeg	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mort., Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4373
Local Reg. No. 73
Reg. Dist. No. 500-602

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF [illegible] (If in hospital or place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): WILMA
b. (Middle): A.
c. (Last): MILLER

4. DATE OF DEATH (Month) (Day) (Year): Sept. 28, 1969

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 29, 1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months 0, Days 29 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Tekoa, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William W. Sherrod — BIRTHPLACE: Calif.
14. MOTHER'S MAIDEN NAME: Agnes Warwick — BIRTHPLACE: Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-24-0656B
17. INFORMANT'S OWN SIGNATURE: A V Miller — ADDRESS: Am. Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1560

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Gall Bladder — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-28, 1969, *to* 9-28, 1969, *that I last saw the deceased alive on* 9-28, 1969, *and that death occurred at* ___ P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 255 T. A. Hunt MD
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 10-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-1-69
24c. NAME OF CEMETERY OR CREMATORY: Fallsview Cemetery
24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: 10-5-69
REGISTRAR'S SIGNATURE: Irene Deeg
25. EMBALMER: H. L. Davis — LICENSE NO.: H. L. Davis E-253
FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4374
Local Reg. No. 166
Reg. Dist. No. 140

RECEIVED
SEP 5 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 700
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 702
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location) 111 Hunter Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Fanny	Marie	Maki	Sept. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	May 4, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Almy, Wyoming
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BIRTHPLACE
14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-24-2760-D
17. INFORMANT'S OWN SIGNATURE Mrs Marlene Erickson ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5900 Cardiovascular Failure — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) hypertensive cardiovascular disease — years
DUE TO (c) chronic pyelonephritis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 Aug, 69, to 1 Sept, 69, that I last saw the deceased alive on 1 Sept, 69, and that death occurred at 9:12 P m., from the causes and on the date stated above.

23a. SIGNATURE Paul T Russell 435 (Degree or title) MD
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 9/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 4, 69
24c. NAME OF CEMETERY OR CREMATORY Mullan Cemetery
24d. LOCATION (City, town, or county) Mullan (State) Idaho

DATE REC'D BY LOCAL REG. 9-2-69
REGISTRAR'S SIGNATURE Dale Cornell
25. EMBALMER Dale L. Cornell
LICENSE NO. E-406
FIRM NAME Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 12 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4375
Local Reg. No. 65
Reg. Dist. No. 142

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (In this place): 4yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shoshone Co. Nursing Ho. 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Enaville
d. STREET ADDRESS (If rural, give location): Enaville Hotel

3. NAME OF DECEASED (Type or Print)
a. (First): Olaf
b. (Middle):
c. (Last): Olson

4. DATE OF DEATH (Month) (Day) (Year): Sept. 9, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Sept. 27, 1894
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Logging
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unobtainable — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-05-3069
17. INFORMANT'S OWN SIGNATURE: × Josie Bates — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach c̄ Metastases — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-13, 1964, *to* 9-9-, 1969, *that I last saw the deceased alive on* 9-9-, 1969, *and that death occurred at* 12:55 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. M. Peterson, M.D. 414
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 9-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/11/1969
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 9-15-69
REGISTRAR'S SIGNATURE: Joe Irvine
25. EMBALMER: Dean G. Petersen — LICENSE NO.: E 534

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell Maisel Fun'l Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4376
Local Reg. No. 69
Reg. Dist. No. 142

RECEIVED Bureau of Vital Statistics SEP 22 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL - Page
DURATION OF STAY (in this place) 15 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Box 565 (Residence) 400

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL - Page
d. STREET ADDRESS (If rural, give location) Box 565 (Residence)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ORA	FRANCIS	FOSTER	Sept. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	divorced	Dec. 7, 1910	58				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Waynesville, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Foster	Illinois	Effie Bebout	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	517-01-6877	Mrs. Effie Foster	Hamilton, Mont.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4199

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-10 *1969, to* 9-10 *, 1969, that I last saw the deceased alive on* 9-10 *, 1969, and that death occurred at about* 6:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson 414	M.D.	Wallace, Idaho	9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 15, 1969	Riverview Cemetery	Hamilton, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-18-69	Joe Justice	Dean M. Putnam	E-534

FIRM NAME Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4377
Local Reg. No. 68
Reg. Dist. No. 142

Certificate of Death

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. W. Shoshone Gen. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cataldo
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Lee
c. (Last): Moon

4. DATE OF DEATH (Month) (Day) (Year): Sept. 10, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Febr. 27, 1941
9. AGE (In years last birthday): 28 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Logging
11. BIRTHPLACE (State or foreign country): Wallace, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William h. Moon — BIRTHPLACE: North Dakota
14. MOTHER'S MAIDEN NAME: Audrey Webster — BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1960-1966
16. SOCIAL SECURITY NO.: 519-42-5522
17. INFORMANT'S OWN SIGNATURE: El Allen — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fractured Neck — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fractured Right Shoulder
DUE TO (c): Severe Contusion of right neck + chest

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Internal Injuries

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Logging near Kellogg
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-10-69 6:50 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Hit by dead snag

22. *I hereby certify that I attended the deceased from* 9-10, 1969, *to* 9-10, 1969, *that I last saw the deceased alive on* 9-10, 1969, *and that death occurred at* 6:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. M. Peterson, M.D. 414
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 9-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/13/1969
24c. NAME OF CEMETERY OR CREMATORY: Forest Lawn
24d. LOCATION (City, town, or county) (State): Coeur D8 Alene, Idaho

DATE REC'D BY LOCAL REG.: 9-18-69
REGISTRAR'S SIGNATURE: Joe Irvine
25. EMBALMER: Russell D. Mikel — LICENSE NO.: E-520

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell Maisel Fun'l Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 23 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 07 1994

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 22 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4378
Local Reg. No. 69
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 401
b. CITY OR TOWN Kellogg
c. LENGTH OF STAY (in this place) 1 mon.
d. FULL NAME OF HOSPITAL OR INSTITUTION West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Smelterville
d. STREET ADDRESS (If rural, give location) 116 Northview

3. NAME OF DECEASED (Type or Print)
a. (First) AGNES
b. (Middle) VIOLA
c. (Last) FILBIN

4. DATE OF DEATH (Month) (Day) (Year) Sept. 11, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH April 15, 1905

9. AGE (In years last birthday) 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper 19

10b. KIND OF BUSINESS OR INDUSTRY retail sales

11. BIRTHPLACE (State or foreign country) Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Theodore Strope
BIRTHPLACE Pennsylvania

14. MOTHER'S MAIDEN NAME Anna Crane
BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 531-20-1496

17. INFORMANT'S OWN SIGNATURE X Ada D. Wossetts
ADDRESS Smelterville, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

398X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) rheumatic heart disease — INTERVAL BETWEEN ONSET AND DEATH ? years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. pneumonia, chronic renal disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/25, 1968, *to* 9/10, 1969, *that I last saw the deceased alive on* 9/18/69, 19____, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Keith Dahlberg 811 (Degree or title) MD

23b. ADDRESS 204 Oregon St. Kellogg

23c. DATE SIGNED 9/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Sept. 13, 1969

24c. NAME OF CEMETERY OR CREMATORY Sunset Hills

24d. LOCATION (City, town, or county) Kirkland, Washington (State)

DATE REC'D BY LOCAL REG. 9-18-69

REGISTRAR'S SIGNATURE

25. EMBALMER Russell D. Maisel
LICENSE NO. E-520
FIRM NAME Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4379
Local Reg. No. 172
Reg. Dist. No. 140

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries - Rural
c. LENGTH OF STAY (in this place): 14 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home, Rt. 3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries 400
d. STREET ADDRESS (If rural, give location): Route #3

3. NAME OF DECEASED (Type or Print): a. (First) Martha b. (Middle) Gray c. (Last) Moe

4. DATE OF DEATH: (Month) Sept. (Day) 15 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 12, 1912

9. AGE (In years last birthday): 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Laws
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Mabel Kayia
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: C. C. Moe ADDRESS: Rt. 3, St. Maries

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cirrhosis of liver — 6 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA *19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at* 8 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: B. A. Rapp (Degree or title) M.D
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 9-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 10-9-69
REGISTRAR'S SIGNATURE: Mae Larsen
25. EMBALMER: Gerald Browning
LICENSE NO.: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4380
Local Reg. No. 70
Reg. Dist. No. 142

RECEIVED
OCT 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Hospital, 41

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wardner
d. STREET ADDRESS (If rural, give location): 1012 Main

3. NAME OF DECEASED (Type or Print): a. (First) THOMAS b. (Middle) c. (Last) OWENS

4. DATE OF DEATH: (Month) Sept. (Day) 17, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 4, 1894

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist 07

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Wales

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Owens
BIRTHPLACE: Wales

14. MOTHER'S MAIDEN NAME: Margaret
BIRTHPLACE: Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-03-4697

17. INFORMANT'S OWN SIGNATURE: x Mrs Thomas Owens
ADDRESS: Wardner, Idaho

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 18, 1964, *to* Sept 17, 1969, *that I last saw the deceased alive on* Sept 17, 1969, *and that death occurred at* 11:10 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. 461
23b. ADDRESS: Kellogg Idaho
23c. DATE SIGNED: Sept 19 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sep. 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 10-9-69
REGISTRAR'S SIGNATURE: Joe Keane

25. EMBALMER: Dean D. Peterson
LICENSE NO.: E-534
FIRM NAME: Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 27 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4381
Local Reg. No. 167
Reg. Dist. No. 140

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shoshone County Nursing Home 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gem
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Grace
b. (Middle):
c. (Last): Lehman

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 9, 1892
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Mica, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-16-2399D
17. INFORMANT'S OWN SIGNATURE: X Edward White — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arteriosclerotic cardiovascular disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* past several yrs *19___, to* 9/18/69 *19___, that I last saw the deceased alive on* 9/18/69 *, 19___, and that death occurred at* 5:00 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert J. Russell M.D. 435
23b. ADDRESS: Wallace Idaho
23c. DATE SIGNED: 9/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-20-69
24c. NAME OF CEMETERY OR CREMATORY: Nine Mile Cemetery
24d. LOCATION (City, town, or county) (State): Wallace, Idaho

DATE REC'D BY LOCAL REG.: 9-20-69
REGISTRAR'S SIGNATURE: Dale L. Cornell
25. EMBALMER: Dale L. Cornell
LICENSE NO.: E-406

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4382
Local Reg. No. 168
Reg. Dist. No. 140

BIRTH NO.

RECEIVED
OCT 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Avery
c. LENGTH OF STAY (In this place): 2hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 Miles N. of Avery

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst
d. STREET ADDRESS (If rural, give location): Lewiston Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RICHARD	DALE	KRAUS	Sept. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	July 1, 1950	19				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Zinc Plant Worker	Mining	Kellogg, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eldon Kraus	Idaho	Tilley	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-56-4958	X Eldon S. Kraus	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Comminuted Fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH: 1 second

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Crushed Posterior Superior Chest
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	Highway-County 406	Avery (2 Mi N) Shoshone 400 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
9-20-69 about 1:00 A.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Car ran off Highway & down embankment

22. *I hereby certify that I attended the deceased from* 9-20 *1969, to* 9-20, *1969, that I last saw the deceased alive on* 9-20, *1969, and that death occurred at* about 1:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. M. Peterson	M.D.	Wallace Idaho	9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/24/1969	Shoshone Mem. Grdns.	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-29-69	Dale Cornell	Dale L. Cornell	E 408

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Maisel Fun'l Chapel

DUTIES: OCT 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4383
Local Reg. No. 169
Reg. Dist. No. 140

BIRTH NO.

RECEIVED STATE OF IDAHO

OCT 1 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 138
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA East Shoshone Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mullan
d. STREET ADDRESS (If rural, give location): Mill Road

3. NAME OF DECEASED (Type or Print): a. (First) Francis; b. (Middle) Nicholas; c. (Last) Flood

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 5, 1912

9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Repairmen 07

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 293-03-6659

17. INFORMANT'S OWN SIGNATURE: X Mrs. Kay Gold — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-21, 1969, *to* 9-21, 1969, *that I last saw the deceased alive on* 9-21, 1969, *and that death occurred at* 9:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: G. M. Peterson, M.D. (Degree or title)

23b. ADDRESS: Wallace, Idaho

23c. DATE SIGNED: 9-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-25-69

24c. NAME OF CEMETERY OR CREMATORY: Mullan Cemetery

24d. LOCATION (City, town, or county) (State): Mullan, Idaho

DATE REC'D BY LOCAL REG.: 9-29-69

REGISTRAR'S SIGNATURE: Dale L. Cornell

25. EMBALMER: Dale L. Cornell

LICENSE NO.: E- 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form OH-63021

DUTIES: OCT 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4384
Local Reg. No. 71
Reg. Dist. No. 142

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Shoshone 400 — OCT 10 1969

b. CITY OR TOWN: Silverton — c. LENGTH OF STAY in this place: 3 mon.

d. FULL NAME OF HOSPITAL OR INSTITUTION: Shoshone Nursing Home 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: Shoshone 401

c. CITY OR TOWN: Kellogg

d. STREET ADDRESS (If rural, give location): 514 W. Mullan

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDWARD		PETTIT	Sept. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	June 13, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintenance crew 08	city	Smith Lake, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jonas Pettit	unknown	Cecile (unknown)	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War I	501-10-3880	X Mamie L Horne	Kellogg, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage	7 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart	5 years
DUE TO (c)	a Brain Accident	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Essential Hypertension	Several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Kellogg Shoshone Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1964, *to* 27 Sept, 1967, *that I last saw the deceased alive on* 6 Jan, 1969, *and that death occurred at* 4 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glen M. Aklund 539	MD	Kellogg Idaho	30 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 30	Shoshone Memorial	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-2-69	Joe Horne	Russell D. Mikel	E-520

FIRM NAME: Cornell's Maisel Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4385
Local Reg. No. 170
Reg. Dist. No. 170

BIRTH NO.

OCT 8 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): 1137 Canyon Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	Russell	Smith	Sept. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	July 27, 1905	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Milwaukee, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Smith	Unknown	Hannah Hohnson	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	516-03-5661	Mrs. Myrtle Leonard	

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-27 *1969, to* 9-27, *1969, that I last saw the deceased alive on* 9-27, *1969, and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. M. Peterson	M.D.	Wallace, Idaho	10-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-3-69	Nine Mile Cemetery	Wallace, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-4-69	Dale Cornell	DAle Cornell	E - 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4386
Local Reg. No. 72
Reg. Dist. No. 142

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

OCT 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF (If not in this place) 11days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital 401

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 116 W. Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) Steve
b. (Middle)
c. (Last) Crljen

4. DATE OF DEATH (Month) (Day) (Year) Sept. 30, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Sept. 28, 1891
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner 07
10b. KIND OF BUSINESS OR INDUSTRY Mining
11. BIRTHPLACE (State or foreign country) Sinj, Yugoslavia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unobtainable — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unobtainable — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-03-2516AX
17. INFORMANT'S OWN SIGNATURE Victoria Leila — ADDRESS Kellogg, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

600X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	probable septicemia	1-2 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	chronic urinary retention + catheter	2 weeks
DUE TO (c)	cerebral thrombosis	2 weeks
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	prostatic hypertrophy, uremia	a year or more

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/1, 1968, *to* 9/30, 1969, *that I last saw the deceased alive on* 9/30, 1969, *and that death occurred at* 4:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Keith Dahlberg 811 (Degree or title) MD
23b. ADDRESS 204 Oregon St. Kellogg
23c. DATE SIGNED 10/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/4/1969
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) (State) Kellogg, Idaho

DATE REC'D BY LOCAL REG. 10-7-69
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Dean H. Peterson — LICENSE NO. E-534
FIRM NAME Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4387
Local Reg. No. D-320
Reg. Dist. No. 460

BIRTH NO.

RECEIVED SEP 29 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 327 Walnut St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 327 Walnut St.

3. NAME OF DECEASED (Type or Print): a. (First) PATRICIA b. (Middle) A. c. (Last) STURTEVANT

4. DATE OF DEATH (Month) (Day) (Year): August 25, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 20, 1934

9. AGE (In years last birthday): 35
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): ElPaso, Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: R. Morris
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Jessie Finkbone
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 525-58-4345

17. INFORMANT'S OWN SIGNATURE: Howard C. Sturtevant
ADDRESS: Twin Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5718

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Edema Pulmonary Severe — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fat Thanerosis Liver Extreme — days to Mos.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: History of Chronic Ethanol ingestion

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Cloyce C. Edwards 333 (Degree or title): Coroner

23b. ADDRESS: R#3 Twin Falls, Ida.

23c. DATE SIGNED: 8/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 8/27/1969

24c. NAME OF CEMETERY OR CREMATORY: Masonic Cemetery

24d. LOCATION (City, town, or county) (State): Las Cruces, New Mexico

DATE REC'D BY LOCAL REG.: Sept 25, 1969

REGISTRAR'S SIGNATURE: Marie D. Marsh

25. EMBALMER

LICENSE NO.: 343

FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 2 9 1969
OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

NOV 3 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4388
Local Reg. No. D-288
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421 SEP 8 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 c. LENGTH OF STAY (If in hospital) Bureau of Vital Statistics	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143	d. STREET ADDRESS (If rural, give location) 354 3rd Ave. East

3. NAME OF DECEASED (Type or Print) a. (First) Elmer	b. (Middle) Elsworth	c. (Last) Leichliter	4. DATE OF DEATH (Month) (Day) (Year) September 1, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct.21, 1892	9. AGE (In years last birthday) 76 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Clayton, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Leichliter	BIRTHPLACE Conolsville, Penn.	14. MOTHER'S MAIDEN NAME Thursey Norris	BIRTHPLACE Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-07-8346	17. INFORMANT'S OWN SIGNATURE x Goldie Leichliter	ADDRESS (same)	

4339

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Vascular Thrombosis of	7-2-69
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Right Mid Cerebral AA	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Hydrostatic pneumonia	3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* June 17, 1969, *to* Sept 1, 1969, *that I last saw the deceased alive on* Sept 1, 1969, *and that death occurred at* 11:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE C. F. Winster M.D. (Degree or title)	23b. ADDRESS Twin Falls, Idaho 204 4th Ave. East	23c. DATE SIGNED 9/4/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept.4,1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301
DATE REC'D BY LOCAL REG. September 5, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Jerry D. Holman	LICENSE NO. E-516

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 10 1969

MAY 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4389
Local Reg. No. D-303
Reg. Dist. No. 460

BIRTH NO. 69-9630

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 — SEP 18 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 283 Sidney Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LUKE	JAMES	THIEMANN	September 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Caucasian	Single	Sept. 1, 1969		1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT 02		Twin Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Danny Thiemann	Utah	Shirley Hensley	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	NONE	† Shirley J. Thiemann	Twin Falls

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Prematurity	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Neonatal	
DUE TO (c)	Atelectasis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

7769

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 5:05P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Eloyce O. Edwards 583 Coroner	R# 3 Twin Falls Ida.	Sept 7-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 9, 1969	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 17, 1969	Marva D. Marsh	Edgar J. Robertson	E-507

FIRM NAME: WHITE MORTAURY

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4390
Local Reg. No. D-391
Reg. Dist. No. 46 0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420 SEP 8 1969
b. CITY OR TOWN Kimberly
c. LENGTH OF STAY IN (this place) 4 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION Mountain View Conv. Center 397

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). 421
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN Twin Falls
d. STREET ADDRESS 262 Sixth Avenue East

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES
b. (Middle) WILLIAM
c. (Last) ALDRICH

4. DATE OF DEATH (Month) (Day) (Year) Sept. 3, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 26, 1884
9. AGE (In years last birthday) 85
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY Grocery
11. BIRTHPLACE (State or foreign country) Toledo, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Sylvester A. Aldrich
BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Mary E. Youngman
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) - - - - - -
16. SOCIAL SECURITY NO. 518-09-0225
17. INFORMANT'S OWN SIGNATURE Twin Falls ADDRESS Charles R. Aldrich Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 4, 19 47, *to* September 3, 19 69, *that I last saw the deceased alive on* April 24, 19 69, *and that death occurred at* 9:10a. m., *from the causes and on the date stated above.*

23a. SIGNATURE Dean H. Affleck MD (Degree or title)
23b. ADDRESS 231 4th Avenue North, Twin Falls, Idaho
23c. DATE SIGNED 5 Sept 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. September 5, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Wilson J. Boyd
LICENSE NO. E-490

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 11 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4391
Local Reg. No. D-294
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Charles	Lark	Sept. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed	Mar. 16, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farm	Big Cottonwood, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Erastus Robert Lark	Yorkshire, England	Mary Olson	Iowa City, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Beth J. Shaw	

MEDICAL CERTIFICATION

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glayce O. Edwards 583	Coroner	R#3 Twin Falls, Ida.	Sept. 8-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal-burial 3	Sept. 3, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 9, 1969	Marva D. Marsh	Jerry D. Holman	E-516

FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

BIRTH NO. SEP 1 8 1969

Certificate of Death
STATE OF IDAHO

State File No. 4392
Local Reg. No. D-301
Reg. Dist. No. 460

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Bureau of Vital Statistics Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 2 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 143 Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 816 12th Avenue North

3. NAME OF DECEASED (Type or Print) a. (First) ORMAN b. (Middle) L. c. (Last) FORBES
4. DATE OF DEATH (Month) Sept. (Day) 4, (Year) 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 30, 1891
9. AGE (In years last birthday) 78 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groceryman 33
10b. KIND OF BUSINESS OR INDUSTRY Retailer
11. BIRTHPLACE (State or foreign country) Wadena, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Forbes BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME Emma Coons BIRTHPLACE No Record
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 540-07-6409
17. INFORMANT'S OWN SIGNATURE Mrs O. L. Forbes ADDRESS 816 12th N. Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cor Pulmonale — Years
DUE TO (c) Pulmonary Emphysema — Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 4, 1963, *to* Sept. 3, 1969, *that I last saw the deceased alive on* Sept. 3, 1969, *and that death occurred at* 4:39 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS L22 9th Ave. No. Buhl, Ida.
23c. DATE SIGNED 9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/8/69
24c. NAME OF CEMETERY OR CREMATORY Buhl
24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. September 16, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER George Farmer
LICENSE NO. E-480
FIRM NAME ALBERTSXON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 24 1969
OCT 28 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4393
Local Reg. No. D-295
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor Nursing Home 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 83328
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GUSTAV	CAESAR	BONNICHSEN	September 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Caucasian	Never Married	Nov. 28, 1884	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Caesar Bonnichsen	Germany	Jane Dowson	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-14-8779	X Everett Bonnichsen	Filer, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4379

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic Brain Syndrome — INTERVAL BETWEEN ONSET AND DEATH: 6 - 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic Pneumonia — 2-3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/30/65, 19__, *to* 9/6/69, 19__, *that I last saw the deceased alive on* March 19 69, *and that death occurred at* 12:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD 578	204 4th Ave. E. Twin Falls, Ida.	9/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	9.8.69	Indian Creek Cem.	ColumbusJunction, Iowa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 9, 1969	Marva D. Mask	Jerry D. Holman	E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4394
Local Reg. No. D-592
Reg. Dist. No. 460

BIRTH NO.

RECEIVED SEP 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 273 Skyview Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 640 Filer Ave. West

3. NAME OF DECEASED (Type or Print) a. (First) Bertha b. (Middle) Ballinger c. (Last) Reynolds

4. DATE OF DEATH (Month) (Day) (Year) September 7, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Feb. 6, 1874

9. AGE (In years last birthday) 95
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY Education

11. BIRTHPLACE (State or foreign country) Pleasant Grove, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James McClure Ballinger
BIRTHPLACE Kentucky

14. MOTHER'S MAIDEN NAME Elnora Warner
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-60-8507

17. INFORMANT'S OWN SIGNATURE Howard B Reynolds
ADDRESS Idaho Twin Falls,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) C Chronic Brain Syndrome — 7 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cellulitis of face — 2 weeks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-25, 1964, to 9-7, 1969, that I last saw the deceased alive on 8-23, 1969, and that death occurred at 6:00a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 578

23b. ADDRESS 204 4th Ave. E. Twin Falls, Ida.

23c. DATE SIGNED 9/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 9, 1969

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) Twin Falls, Idaho 83301 (State)

DATE REC'D BY LOCAL REG. September 9, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Jerry L. Holman

LICENSE NO. E-516

FIRM NAME: White Mortuary Twin Falls, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 24 1969

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

SEP 1 8 1969

Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4395
Local Reg. No. D-300
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Twin Falls 420	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl — c. LENGTH OF STAY (In this place): 20 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 924 N. Broadway Avenue 000	d. STREET ADDRESS (If rural, give location): 924 N. Broadway Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
KENNETH	WAYNE	BUELL	Sept. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 11, 1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Meat Cutter 21	Packing	Miltonville, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Arthur Buell	Kansas	Edna Melissa Lindsay	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		509-09-2670	Rita Bremers LLOYD CIRCLE LOT 3	Buhl, Ida.

1529

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Carcinomatosis	months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Carcinoma of small bowel	Three years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 26, 1964, *to* Sept. 9, 1969, *that I last saw the deceased alive on* July 3, 1969, *and that death occurred at* 7:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
C W Cullings 118 (Degree or title) MD	122 9th Ave. No. Buhl, Ida.	9-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	9/12/69	Buhl	Buhl	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 16, 1969	Marva D. Marsh	George Farmer	E-480

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 19 1969
JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4396
Local Reg. No. D-297
Reg. Dist. No. 460

BIRTH NO.

SEP 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421 a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301	c. ENGINEERING STAT (In this place)
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Washington Street South 000	d. STREET ADDRESS (If rural, give location) Washington Street South

3. NAME OF DECEASED (Type or Print)	a. (First) LYNN	b. (Middle) S.	c. (Last) STEWART	4. DATE OF DEATH (Month) (Day) (Year) September 9,1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH September 6th, 1901	9. AGE (In years last birthday) 68 yrs; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RealEstateBroker 24	10b. KIND OF BUSINESS OR INDUSTRY Realters	11. BIRTHPLACE (State or foreign country) Hopkins,Missouri	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James S. Stewart	BIRTHPLACE Louderdale,Wisconsin	14. MOTHER'S MAIDEN NAME Mary Elizabeth Rush	BIRTHPLACE Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-07-8227	17. INFORMANT'S OWN SIGNATURE x Jenny Stewart	ADDRESS T.F. Idaho

4549

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial insufficiency	1 Day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Phlebothrombosis	4 Mo.
DUE TO (c)	Varicosities both lower extremities	Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Right pulmonary infarction; paroxysmal hypertension from kidney infarction.	4 Mo.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1964, *to* September, 1969, *that I last saw the deceased alive on* September 3, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 246. Glenn A. Ross, M.D. (Degree or title)	23b. ADDRESS TwinFalls,Idaho	23c. DATE SIGNED 9.10.69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9.12.69	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Falls,Idaho
DATE REC'D BY LOCAL REG. September 12, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Jerry J. Holman	LICENSE NO. E-516

FIRM NAME: White Mortuary Twin Falls,Ida

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 16 1969
OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

OCT 24 1984
MAR 09 2000

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

SEP 1 8 1969

Certificate of Death

STATE OF IDAHO

State File No. 4397
Local Reg. No. D-299
Reg. Dist. No. 460

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls Idaho
c. LENGTH OF STAY (in this place) 3 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 909 J Street

3. NAME OF DECEASED (Type or Print)
a. (First) Svea
b. (Middle)
c. (Last) Lundgren

4. DATE OF DEATH (Month) (Day) (Year) Sept 10 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec 24 1905
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired House wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Redin — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Amanda Lindell — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 261-88-6273
17. INFORMANT'S OWN SIGNATURE: x Lucille Peavey — ADDRESS: 904-10th

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) A.S.C.V.D. — years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10-69, 19__, *to* 9-10, 1969, *that I last saw the deceased alive on* 9-10-69, 19__, *and that death occurred at* 9 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Ben K. Humphrey M.D. 253 (Degree or title)
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 9-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 13 1969
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: September 15, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Robert C. Walk
LICENSE NO.: E 294

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4398
Local Reg. No. D-304
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 1111 Syringa

3. NAME OF DECEASED (Type or Print)
a. (First): DORIS
b. (Middle): E.
c. (Last): OLSEN

4. DATE OF DEATH (Month) (Day) (Year): Sept. 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 5, 1915
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Filer, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Guy Humphrey — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Ethel Davis — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 09 7887
17. INFORMANT'S OWN SIGNATURE: X [signature] — ADDRESS: Twin Falls, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Laennec's Cirrhosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/16, 1969, *to* 9/11, 1969, *that I last saw the deceased alive on* 9/11, 1969 *and that death occurred at* 2:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Jerome 918 [signature] MD
23b. ADDRESS: Twin Falls Clinic
23c. DATE SIGNED: 9/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: September 17, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JUL 10 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4399
Local Reg. No. D-296
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls (421) SEP 1 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY IN (Bureau of Vital Statistics)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. (43)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (42c)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): Route# 3

3. NAME OF DECEASED (Type or Print): a. (First) KATHLEEN b. (Middle) J. c. (Last) UNANDER

4. DATE OF DEATH (Month) (Day) (Year): Sept. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	March 22, 1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Home	Kimberly, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clyde J. Straughn	Indiana	Pearl Miles	Gibbensville, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-12-2461	Neal Unander	Twin Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1538 Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 4 Mon.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5/9, 19 69 *to* 9/11, 19 69 *that I last saw the deceased alive on* 9/10, 19 69 *and that death occurred at* 8:20a *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Roy D. Shaw M.D. (Degree or title)	284 Main St.	9/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 15, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 12, 1969	Marva D. Marsh	Jerry D. Holman	E-516

FIRM NAME: White Mortuary Twin Falls, Ida

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 16 1969

MAR 20 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 25 2011

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4400
Local Reg. No. D-306
Reg. Dist. No. 460

BIRTH NO. SEP 22 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 021
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 5 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION: Hazeldel Manor Rest Home 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 720
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 216 12th Avenue North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MANFRED	G.	HEILMAN	Sept. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Jan. 3, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Monte Vista, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
No Record		No Record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I	4123	Garner D. Stephens	Twin Falls Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Arteriosclerotic Heart Disease —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Heart Failure —

INTERVAL BETWEEN ONSET AND DEATH: Yrs. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 13, 1964 *to* Sept 13, 1969, *that I last saw the deceased alive on* Sept 1, 69, *and that death occurred at* 4 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
417 Willard R. [illegible]	Twin Falls Ida	Sept 16 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/15/69	Buhl	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 18, 1969	Marna D. Marsh	George Farmer	E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 22 1969

OCT 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED SEP 22 1969 Bureau of Vital Statistics

State File No. 4401
Local Reg. No. D-312
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Skyview Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 290 Locust

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DESSIE		KUHLMAN	Sept. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Dec. 9, 1881	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Sweet Springs, Mo.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	unknown	Unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		unknown	[signature]	Twin Falls, Ida

MEDICAL CERTIFICATION

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Thrombosis	Immediate
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary Arteriosclerosis	2 years
DUE TO (c)	Generalized Arteriosclerosis	10 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	None	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 17, 1967, *to* Sept. 13, 1969, *that I last saw the deceased alive on* Sept. 13, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. H. Clark, MD	632 Main Ave. N. Twin Falls, Idaho	9-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1969 Sept. 17,	Sunset Memorial Park	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 19, 1969	Marva D. Marsh	Donald J. Hamilton	E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 0 1969

MAY 2 1 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. MAY 2 1 1976
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease,. will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4402
Local Reg. No. D-302
Reg. Dist. No. 460

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls — SEP 1 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 273 No. Locust

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Valley Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BURLEY	R.	GERSON	Sept. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	September 22, 1908	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Spokane, Washington
12. CITIZEN OF WHAT COUNTRY US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Gerson	Pennsylania	Elizabeth Burka	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) yes WW2 (If yes, give war or dates of service) Air Corps
16. SOCIAL SECURITY NO. 422-05-1489
17. INFORMANT'S OWN SIGNATURE Carolyn Gerson ADDRESS Twin Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction	Sudden.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary artery disease.	5 years.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	1. Chronic obstructive emphysema. 2. Cirrhosis of liver.	2 years. 5 years.

4109

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-28-69, 19____, *to* 9-14-69, 19____, *that I last saw the deceased alive on* 9-11-69, 19____, *and that death occurred at* 9:30p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George S. Brown MD	Twin Falls, Idaho	9.15.69

24a. BURIAL, CREMATION, REMOVAL, etc.	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9.17.69	Riverside Cem.	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
September 17, 1969	Marva D. Marsh	Ronald D. Hamilton	E-470

FIRM NAME: White Mortuary Twin Falls, Ida

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 24 1969

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4403
Local Reg. No. D-310
Reg. Dist. No. 460

BIRTH NO.

RECEIVED SEP 22 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY IN THIS PLACE: 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 42
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 428 N. Main

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) WASHINGTON c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year): Sept. 14, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: Jan. 11, 1888

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 08

10b. KIND OF BUSINESS OR INDUSTRY: City

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Allen Johnson
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Rena Nix
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: 518-28-4575

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: x Maggie A. Holston Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A. — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Mullitus — 20 years
DUE TO (c) A.S.H.D. & generalised A.S. — 40 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9/11, 1969, *to* 9/14, 1969, *that I last saw the deceased alive on* 9/14, 1969 *and that death occurred at* 3:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD 420
23b. ADDRESS: Kimberly, Idaho
23c. DATE SIGNED: 9-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9-18-69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept 18, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Hall L. Patterson
LICENSE NO.: E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4404
Local Reg. No. D-314
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 13 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 750 All Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 750 All Avenue

3. NAME OF DECEASED (Type or Print): a. (First) BESSIE b. (Middle) c. (Last) LEE

4. DATE OF DEATH (Month) (Day) (Year): Sept. 14, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 9, 1888
9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Greenville, Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Loggins — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Martha (Unknown) — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 499-28-3095
17. INFORMANT'S OWN SIGNATURE: Oscar Lee — ADDRESS: Twin Falls, Idaho

4321

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Congestive Heart Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) due to Hypertensive Arterio Sclerotic Heart disease 3 wks

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-7, 1969, *to* 9-14, 1969, *that I last saw the deceased alive on* 9-9, 1969, *and that death occurred at* 7:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Vern H. Anderson (Degree or title) MD
23b. ADDRESS: Buhl, Ida.
23c. DATE SIGNED: 9-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 22, 1969
REGISTRAR'S SIGNATURE: Mavis D. Marsh
25. EMBALMER: Dale S. Patterson
LICENSE NO.: E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

State File No. 4405
Local Reg. No. D-305
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazeldel Manor Nursing Home 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 640 Filer Ave. West

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle)
c. (Last) MEUSER

4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Dec.21,1890
9. AGE (In years last birthday) 78
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Emerick, Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Herman Meuser
BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Clara Ott
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW1 3
16. SOCIAL SECURITY NO. 091-22-6488
17. INFORMANT'S OWN SIGNATURE Hugh U. Phillips
ADDRESS White Mortuary

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion c̄ Infarct — INTERVAL BETWEEN ONSET AND DEATH ½ hr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen arteriosclerosis — years
DUE TO (c) arteriosclerotic heart disease — years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. old age

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1966, *to* Sept 14, 1969, *that I last saw the deceased alive on* Sept 14, 1969, *and that death occurred at* 8:35a *m., from the causes and on the date stated above.*

23a. SIGNATURE R. A. Drake M.D. 146 (Degree or title)
23b. ADDRESS 594 Hazeldel Clinic
23c. DATE SIGNED 9 16 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1969 Sept.16,
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. September 17, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4406
Local Reg. No. D-309
Reg. Dist. No. 460

BIRTH NO.

SEP 22 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 83328
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143	d. STREET ADDRESS (If rural, give location) 721 Idaho St.

3. NAME OF DECEASED (Type or Print)	a. (First) ALICE	b. (Middle) MARTHA	c. (Last) PATTERSON	4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 5, 1890	9. AGE (In years last birthday) 79 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Farnam, Nebraska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Gardner	BIRTHPLACE Indiana	14. MOTHER'S MAIDEN NAME Ellen McPheeters	BIRTHPLACE Indiana	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-09-1238	17. INFORMANT'S OWN SIGNATURE J. M. Patterson	ADDRESS Rt #1 Buhl	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1719

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Kaposis Sarcoma — INTERVAL BETWEEN ONSET AND DEATH 8 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypoglycemia 2° to above

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/11, 1969, *to* 9/15, 1969, *that I last saw the deceased alive on* 9/14, 1969, *and that death occurred at* 2:10a *m., from the causes and on the date stated above.*

23a. SIGNATURE Roy O. Shaub M.D. 466 (Degree or title)	23b. ADDRESS 284 Martin St. T.F. Ida	23c. DATE SIGNED 9/16/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 17, 1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) Twin Falls, Idaho 83301 (State)
DATE REC'D BY LOCAL REG. September 18, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Ronald J. Hamilton	LICENSE NO. E-470

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 3 0 2010

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4407
Local Reg. No. D-307
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 1946 Granada Dr

3. NAME OF DECEASED (Type or Print) a. (First) VERNON b. (Middle) c. (Last) RIDDLE
4. DATE OF DEATH (Month) (Day) (Year) September 15, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 15, 1917
9. AGE (In years last birthday) 51 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Certified Public Accountant
10b. KIND OF BUSINESS OR INDUSTRY Own Business
11. BIRTHPLACE (State or foreign country) Max, North Dakota
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Zach Riddle BIRTHPLACE HoldenCounty, Tenn
14. MOTHER'S MAIDEN NAME Martha Waterman BIRTHPLACE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-5345
17. INFORMANT'S OWN SIGNATURE Mrs. Vernon Riddle ADDRESS TwinFalls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) RESPIRATORY INSUFFICIENCY
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) POST OPERATIVE STATUS
DUE TO (c) LUNG CANCER
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/5/ , 1969 , to 9/15 , 1969 , *that I last saw the deceased alive on* 9/15 , 1969 , *and that death occurred at* 11 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE John M. McKee (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 9.16.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 18 Sept. 1969
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. September 18, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Donald D. Hamilton
LICENSE NO. E-420
FIRM NAME: White Mortuary TwinFalls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 24 1969
MAY 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 21 1979
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. OCT 15 1979
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED SEP 22 1969 Bureau of Vital Statistics

State File No. 4408
Local Reg. No. D-311
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY TwinFalls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY TwinFalls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TwinFalls 83301
d. STREET ADDRESS (If rural, give location) 246 Jackson

3. NAME OF DECEASED (Type or Print) a. (First) MAUDE b. (Middle) c. (Last) QUAST

4. DATE OF DEATH (Month) Sept. (Day) 16, (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH May 26, 1891

9. AGE (In years last birthday) 78
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Durham, Kansas

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Pete Anderst
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-40-1235-A

17. INFORMANT'S OWN SIGNATURE X Mrs Gideon Sparks
ADDRESS TwinFalls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5900

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bronchial pneumonia	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Uremia	1 week
DUE TO (c)	Chronic pyelonephritis	1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes melitis	5 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 11 1969 *to* Sept. 16 1969 *that I last saw the deceased alive on* Sept. 16 1969 *and that death occurred at* 2:05A m., *from the causes and on the date stated above.*

23a. SIGNATURE W. H. Quale M.D. (Degree or title)

23b. ADDRESS TwinFalls, Idaho

23c. DATE SIGNED 9.16.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9.19.1969

24c. NAME OF CEMETERY OR CREMATORY Sunset MemorialPark

24d. LOCATION (City, town, or county) (State) Cem. Twin Falls, Idaho

DATE REC'D BY LOCAL REG. September 19, 1969

REGISTRAR'S SIGNATURE Mamie O. Marsh

25. EMBALMER Ronald D. Hamilton

LICENSE NO. E-470

FIRM NAME: Memorial Mortuary TwinFalls, Ida

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 5 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 29 1969

Vital Statistics

State File No. 4409
Local Reg. No. D. 321
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place) Bureau
d. FULL NAME OF HOSPITAL OR INSTITUTION 253 5th Ave North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 253 5th Ave North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Donald	Alan	Fitch	Sept. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	Apr. 6, 1923	46		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Genl	Oakland, Calif.	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harold M. Fitch	St. Joseph, Kansas	Gladys Mae McWea	Rochester, NewYork

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes WW2 US Army	560-28-3389		Twin Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 7-9-69 to 7-19-69
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-9, 1969, to Present, 19____, that I last saw the deceased alive on 9-5, 1969, and that death occurred at ____ p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Albert A Rees M D	Twin Falls, Idaho	9.19.69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9.22.69	Twin Falls Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 25, 1969	Marva D. Marsh	Donald J. Hamilton	E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 3 0 1969

OCT 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
SEP 25 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4410
Local Reg. No. D-313
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH Twin Falls	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205	d. STREET ADDRESS (If rural, give location) Harral Nursing Home

3. NAME OF DECEASED (Type or Print)	a. (First) OVA	b. (Middle) F.	c. (Last) WIGGINS	4. DATE OF DEATH (Month) (Day) (Year) Sept. 17, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 26, 1906	9. AGE (In years last birthday) 63; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Kingston, Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar Y ingst	BIRTHPLACE Arkansas	14. MOTHER'S MAIDEN NAME RFD, # 3 [signature]	BIRTHPLACE Buhl, Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-52-6420	17. INFORMANT'S OWN SIGNATURE Lenore Wright,	ADDRESS Arkansas	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) ① Heart Failure, Arterio sclerotic Heart Disease

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ② Paralysis left arm + left leg, from old skull fracture from car accident

DUE TO (c) ③ urinary incontinence

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Several wks; 3 yrs ago

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-9, 1965, *to* Sept 17, 1969, *that I last saw the deceased alive on* Sept 17, 1969, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Vern H Anderson	(Degree or title)	23b. ADDRESS Buhl, Ida	23c. DATE SIGNED 9-19-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/20/69	24c. NAME OF CEMETERY OR CREMATORY Buhl	24d. LOCATION (City, town, or county) Buhl, (State) Idaho
DATE REC'D BY LOCAL REG. Sept. 22, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER George Farmer	LICENSE NO. E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4411
Local Reg. No. D-319
Reg. Dist. No. 460

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 29 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township place): Twin Falls
c. LENGTH OF STATE (If outside place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: T. Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 439 4th Street North

3. NAME OF DECEASED (Type or Print)
a. (First): IRL
b. (Middle): G.
c. (Last): BEAM

4. DATE OF DEATH (Month) (Day) (Year): September 18, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: January 14, 1899
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintainance Man 06
10b. KIND OF BUSINESS OR INDUSTRY: Young's Dairy
11. BIRTHPLACE (State or foreign country): Daven Port, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isaiah G. Beam — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Emma Rile — BIRTHPLACE: Penna.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 51 9-07-9947A
17. INFORMANT'S OWN SIGNATURE: Mrs Irl G. Beam — Twin Falls, Idaho — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Pulmonary Emphysema & — 8 years
DUE TO (c): Bronchial Asthma — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Benign Prostatic Hypertrophy

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/7, 1969, *to* 9/18/, 1969, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 1:15p. m., *from the causes and on the date stated above.*

23a. SIGNATURE 466 Roy O Shaub MD (Degree or title) M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 9/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/20/69
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 25, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: James C. Reynolds — James C. Reynolds
LICENSE NO.: E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 6 1990

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4412
Local Reg. No. D-316
Reg. Dist. No. 460

BIRTH NO.

RECEIVED SEP 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eden
d. STREET ADDRESS (If rural, give location): Eden

3. NAME OF DECEASED (Type or Print): a. (First) Arthur; b. (Middle) Myron; c. (Last) Black

4. DATE OF DEATH: (Month) September (Day) 18, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 22,1893

9. AGE (In years last birthday): 76
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer-Produce Broker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Deseret-Millard Co., Utah

12. CITIZEN OF WHAT COUNTRY? Us

13. FATHER'S NAME: Daniel Jackson Black- BIRTHPLACE: Rockville-WashCo,Utah

14. MOTHER'S MAIDEN NAME: Phoebe Amanda Henry- BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-38-0053

17. INFORMANT'S OWN SIGNATURE: Karl L. Black ADDRESS: Eden, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4107

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Less than one hour.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arterio-Sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-20-69, 19__, to 9-18-69, 19__, that I last saw the deceased alive on 9-18, 1969, and that death occurred at 3:56 p.m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] (Degree or title): MD

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 9.19.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-22-1969

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park Cem.

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 23, 1969

REGISTRAR'S SIGNATURE: Mamie D. Marsh

25. EMBALMER: [signature]

LICENSE NO.: 343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4413
Local Reg. No. D-317
Reg. Dist. No. 460

BIRTH NO SEP 25 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Bureau of Vital Statistics Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (In this place) 9 years
d. FULL NAME OF HOSPITAL OR INSTITUTION 624 8th Avenue North 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 624 8th Avenue North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MYRTLE		DUNCAN	Sept. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Oct. 30, 1894	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Alma, New Mexico	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ezekiel Day	Tennessee	Eliza Roberts	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	530-24-6215B	Geraldine O'Neil	624 8th Ave. N. Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1560

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of the gall bladder — Months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept. 9, 1961, *to* September 18, 1969, *that I last saw the deceased alive on* September 17, 19 69, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
C. Cullings MD	122 9th Ave. No. Buhl, Idaho	9-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/20/69	Buhl	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 24, 1969	Marva D. Mars	George Farmer	E-480

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

FEB 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4414
Local Reg. No. D-315
Reg. Dist. No. 460

BIRTH NO. 69-9677 RECEIVED SEP 25 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): Route # 1 Earl Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Douglas	Ervin	Hutchins	September 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Singl e	Sept.19,1969		1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---------- 02
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): Twin Falls, Ida ho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kenneth Hutchins — BIRTHPLACE: Rupert, Idaho
14. MOTHER'S MAIDEN NAME: Marsha Hand — BIRTHPLACE: Twin Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ----------
17. INFORMANT'S OWN SIGNATURE: Kenneth Hutchins — ADDRESS: Twin Falls

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7769

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Neonatal Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Prematurity — 1 d.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/19/69, 19__, *to* 9/20, 19 69, *that I last saw the deceased alive on* 9/20, 19 69, *and that death occurred at* 2:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm Wright, MD.	Twin Falls, Idaho.	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept.24,1969	Sunset Memorial Park	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 23, 1969	Marva D. Marsh		343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4415
Local Reg. No. D-398
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Twin Falls b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 c. LENGTH OF STAY (In this place): d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Twin Falls b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301 d. STREET ADDRESS (If rural, give location): 290 Alexander St.

3. NAME OF DECEASED (Type or Print)	a. (First): FAYE	b. (Middle): F.	c. (Last): SKAGGS	4. DATE OF DEATH (Month) (Day) (Year): September 20, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: June 9,1914	9. AGE (In years last birthday): 55 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Webb City, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Walter Carnes	BIRTHPLACE: unknown	14. MOTHER'S MAIDEN NAME: Faith Hudgens	BIRTHPLACE: Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 441-36-5919	17. INFORMANT'S OWN SIGNATURE: Frank F. Skaggs	ADDRESS: Twin Falls	

4109

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Thrombosis	Immediate
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary Arteriosclerosis	Unknown
DUE TO (c)	Rheumatic Heart Disease	Unknown
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	None known	

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 27, 1968, *to* Sept. 20, 1969, *that I last saw the deceased alive on* Sept. 20, 1969, *and that death occurred at* 6:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE: Willard H. Clark M.F. (Degree or title)	23b. ADDRESS: 632 Main Ave. N., Twin Falls	23c. DATE SIGNED: 9-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept.23,1969	24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301
DATE REC'D BY LOCAL REG.: Sept. 24, 1969	REGISTRAR'S SIGNATURE: Marva D. Marsh	25. EMBALMER: Jerry J. Holman	LICENSE NO.: E-516

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4416
Local Reg. No. D-322
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 29 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
d. STREET ADDRESS (If rural, give location): 220 Ash Street North

3. NAME OF DECEASED (Type or Print)
a. (First): GARL
b. (Middle):
c. (Last): RIDGEWAY

4. DATE OF DEATH (Month) (Day) (Year): September 22, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: August 17, 1888
9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Municipal
11. BIRTHPLACE (State or foreign country): Clark, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME / BIRTHPLACE: Willard Shelton Ridgeway, Missouri
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Annie Belle Spurling, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: 518-09-8417
17. INFORMANT'S OWN SIGNATURE / ADDRESS: Goldie Ridgeway, Kimberly, Idaho

4330

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — 1+ year.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Hypertensive cardiovascular disease 1 + year.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10-, 1968, *to* 9-22-, 1969, *that I last saw the deceased alive on* 9-22-, 1969, *and that death occurred at* 8:10p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George E. Brown MD
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 9-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-25-69
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept 25, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Dale P. Patterson
LICENSE NO.: E-451

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Twin Falls Mortuary

1300

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 30 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4417
Local Reg. No. D-32
Reg. Dist. No. 460

BIRTH NO.

RECEIVED OCT 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazeldel Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 362 7th Ave. No.

3. NAME OF DECEASED (Type or Print) a. (First) LAWRENCE b. (Middle) E. c. (Last) BIRD
4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 1/6/1896
9. AGE (In years last birthday) 73 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman--Sugar Factory
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hastings, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Morgan Bird BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME unknown BIRTHPLACE unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. 483-07-4650A
17. INFORMANT'S OWN SIGNATURE x Genevieve Bird ADDRESS Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Far advanced pulmonary emphysema with Bronchiectasis- — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — 3 years
DUE TO (c) with myocardial ischemia

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition due to patient's system being unable to metabolize normally — 6 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-15-1947, 19__ to 9-24-1969, 19__, that I last saw the deceased alive on 9-17-69, 19__ and that death occurred at 2:00 AM, from the causes and on the date stated above. 9-26-69

23a. SIGNATURE (Degree or title) D.A. McCluskey MD
23b. ADDRESS 666 Shoshone St. Twin Falls, Ida.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/26/1969
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Sept. 29, 1969
REGISTRAR'S SIGNATURE Mrs. D. Marsh
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-470

FIRM NAME: White Mortuary, Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4418
Local Reg. No. D-358
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
OCT 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Jerome 272
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Jerome
d. STREET ADDRESS (If rural, give location) R.R.#2

3. NAME OF DECEASED (Type or Print) a. (First) LILA b. (Middle) c. (Last) Walker

4. DATE OF DEATH (Month) (Day) (Year) September 26, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 23, 1903
9. AGE (In years last birthday) 66
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lenox, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hugh Mitchell
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Mary Ryan
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-30-1492
17. INFORMANT'S OWN SIGNATURE Hubert Walker ADDRESS Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma breast c 1743X — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) metastases — 4 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Mar 1965
19b. MAJOR FINDINGS OF OPERATION Carcinoma breast.
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar, 1965, to 9/26/, 1969, that I last saw the deceased alive on 9/26, 1969, and that death occurred at 2:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE Doug W. Warner (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 10-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/30/69
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. October 6, 1969
REGISTRAR'S SIGNATURE Marna D. Mann
25. EMBALMER James C. Reynolds James C. Reynolds
LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4419
Local Reg. No. D-330
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
OCT 8 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Twin Falls b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls c. LENGTH OF STAY (In this place): d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Mem. Hospital	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: T. Falls b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hollister Rural d. STREET ADDRESS (If rural, give location): R.R.#1 Twin Falls

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LILLIAN	C.	HENSTOCK	September 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	March 30, 1910	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Quay, Oklahoma	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Cocannauer	unknown	Mary Colyer	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Carl R. Bruneau	Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

3304

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Anoxia secondary to tracheobronchial obstruction.

DUE TO (c) Weakness of secondary muscles of respiration due to late evolving muscular distrophy.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9/27/69	Retained tracheobronchial secretion.	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/28/64, 19____, *to* 9/28/, 19 69, *that I last saw the deceased alive on* 9/28/69, 19____, *and that death occurred at* 11:30a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Twin Falls, Idaho	10/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/1/69	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER James C. Reynolds	LICENSE NO.
October 6, 1969	Marva D. Marsh	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

FEB 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4420
Local Reg. No. D-326
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls — OCT 7 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer 83328
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First): SAVETTA
b. (Middle): M.
c. (Last): LIKES

4. DATE OF DEATH (Month) (Day) (Year): September 28, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 17, 1895

9. AGE (In years last birthday): 74
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): McPherson, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter Fuller — BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Maude McClellen — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-05-8353

17. INFORMANT'S OWN SIGNATURE: X Ralph Likes — ADDRESS: Filer

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — Years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
1. Arteriosclerotic heart disease — Years
2. Diabetes mellitus — Years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 30, 19 63, *to* September 28, 19 69, *that I last saw the deceased alive on* September 28 19 69, *and that death occurred at* 3:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M Cullum MD

23b. ADDRESS: 122 9th Ave. North Buhl Ida.

23c. DATE SIGNED: 9-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 1, 1969

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: 10-3-69

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER: Jerry D. Holman

LICENSE NO.: E-516

FUNERAL DIRECTOR'S NAME: White Mortuary Twin Falls, Id

Federal Security Agency
United States Public Health Service FORM DH-63021

APR 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4421
Local Reg. No. D-329
Reg. Dist. No. 460

BIRTH NO.

OCT 8 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY T.Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A.Magic Valley Mem.Hospital 143	d. STREET ADDRESS (If rural, give location) 702 3rd Avenue West

3. NAME OF DECEASED (Type or Print) a. (First) PRICILLA	b. (Middle) FAITH	c. (Last) ROBINSON	4. DATE OF DEATH (Month) (Day) (Year) September 28,1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 17,1940	9. AGE (In years last birthday) 29 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Secretary 19	10b. KIND OF BUSINESS OR INDUSTRY Library	11. BIRTHPLACE (State or foreign country) Twin Falls,Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Roberts	BIRTHPLACE Twin Falls,Idaho	14. MOTHER'S MAIDEN NAME Edna Valline	BIRTHPLACE Colorado Springs,Colo.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-44-1238	17. INFORMANT'S OWN SIGNATURE Paul L Roberts	ADDRESS Twin Falls, Idaho	

8199

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severed cervical vertebra — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Massive chest trauma

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1 accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Rural Hiway 06	21c. (CITY, TOWN, OR TOWNSHIP) 3 mi. -W. &2mi. S. 420 (COUNTY) (STATE) Twin Falls, Id	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 28, 1969 6:30 p.m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR? Auto accidnet	

22. *I hereby certify that I attended the deceased from* Did not attend-Coroner's Investigation only *and last saw the deceased alive on* _____, 19____, *and that death occurred at* 7:00p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Cloyce O. Edwards 583 + (Degree or title) Coroner	23b. ADDRESS Twin Falls,Idaho	23c. DATE SIGNED 9/30/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1 0/1/69	24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery	24d. LOCATION (City, town, or county) (State) Twin Falls,Idaho
DATE REC'D BY LOCAL REG. October 6, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER James C. Reynolds James C. Reynolds	LICENSE NO. E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4422
Local Reg. No. D-324
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls — OCT 7 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 207 8th Ave. East

3. NAME OF DECEASED (Type or Print): a. (First) WILLARD F. b. (Middle) c. (Last) WARDELL

4. DATE OF DEATH (Month) (Day) (Year): Sept. 29, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 19, 1886

9. AGE (In years last birthday): 83
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Peoa, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Wardell — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Lueretia Barter — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-28-6109A

17. INFORMANT'S OWN SIGNATURE: Barbara Wardell — ADDRESS: Twin Falls, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 3-4 mon.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Bronchial Asthma, Pulmonary Emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: B. Internal Hemias, Calcific Aortic Stenosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/21, 1964, *to* Sept 29, 1969, *that I last saw the deceased alive on* Sept 29, 1969, *and that death occurred at* 4:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Roy L. Shanks — (Degree or title): MD

23b. ADDRESS: 284 Main St. T.F. Ida

23c. DATE SIGNED: 10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 2, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hazelton Cemetery

24d. LOCATION (City, town, or county) (State): Hazelton, Jerome, Idaho

DATE REC'D BY LOCAL REG.: 10-3-69

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER: Jerry D. Holman

LICENSE NO.: E-516

FIRM NAME: White Mortuary, Twin Falls,

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4423
Local Reg. No. D-331
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
OCT 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION R.R.#3 CRD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY T.Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Twin Falls
d. STREET ADDRESS (If rural, give location) R.R.#3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
AMEAL		HANSING	September 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Sept. 9, 1879	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04		Wichita, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Hansing	Hamburg, Germany	Susan Piper	Joliet, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-42-6630 A	James C. Reynolds	~~Filer~~, Twin Falls Idaho

4272

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Coroner's Investigation only *, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at* 4:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Loyce O. Edwards 583 4	Coroner	Twin Falls, Idaho	10/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/3/69	Twin Falls, Idaho Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER James C. Reynolds	LICENSE NO.
October 6, 1969	Marva D. Marsh	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 1 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4424
Local Reg. No. 10
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Valley 430 OCT 7 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall Bureau of Vital Statistics c. LENGTH OF STAY (In this place) 4½ months	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Lakes Nursing Home 324	d. STREET ADDRESS (If rural, give location) Alpha Community

3. NAME OF DECEASED (Type or Print) a. (First) VIOLA	b. (Middle) A.	c. (Last) HERRICK	4. DATE OF DEATH (Month) (Day) (Year) September 25, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH November 3, 1889	9. AGE (In years last birthday) 79 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Susanville, California	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME S. L. Cantrall	BIRTHPLACE Jacksonville, Oregon	14. MOTHER'S MAIDEN NAME Mary Hackett	BIRTHPLACE Dayton, Nevada	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-58-9603	17. INFORMANT'S OWN SIGNATURE Dorsey C Herrick	ADDRESS Cascade, Ida.	

4369

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebrovascular accident	6 mos
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized arteriosclerosis	5 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hepatic + Kidney insufficiency	2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 1, 1957, *to* 9-25, 1969, *that I last saw the deceased alive on* 9-25-69, 1969, *and that death occurred at* 10 p *m., from the causes and on the date stated above.*

23a. SIGNATURE James H Stewart (Degree or title) MD	23b. ADDRESS McCall Idaho	23c. DATE SIGNED 10-1-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 29, 1969	24c. NAME OF CEMETERY OR CREMATORY Alpha Cemetery	24d. LOCATION (City, town, or county) (State) Valley County, Idaho
DATE REC'D BY LOCAL REG. Oct 2 1969	REGISTRAR'S SIGNATURE Myrtle M Gardner	25. EMBALMER Burton E Walker	LICENSE NO. E-386

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4425
Local Reg. No. 11
Reg. Dist. No. 320

Certificate of Death

RECEIVED
SEP 10 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge (rural)
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Cambridge
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Lee
b. (Middle): Roger
c. (Last): Kester

4. DATE OF DEATH (Month) 9 (Day) 6 (Year) 1969

5. SEX: male
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: 8/18/1948
9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Invalid since birth
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Middleton, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ralph Kester — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Ona Porter — BIRTHPLACE: May, Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Joy Kester — ADDRESS: Cambridge, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3459

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lee Kester was subject to epileptic seizures. Had been at both

ANTECEDENT CAUSES State hospitals in past years, but was at home for

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) visit. Family reported seizures began about 6 A.M. 9/6 and he expired at approx. 12

DUE TO (c) noon. Due to a religious belief, no

II. OTHER SIGNIFICANT CONDITIONS Doctor was summoned. There was no evidence

Conditions contributing to the death but not related to the disease or condition causing death. of suspicious or unusual circumstances.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: To the best of my knowledge & belief, suject died of natural causes.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroner's Investigation, *19*___, *to* _____, *19*___, *that I last saw the deceased alive on* _____, *19*___, *and that death occurred at* app. 12 a. *m., from the causes and on the date stated above.*

23a. SIGNATURE: R. Dale Thomason (Degree or title): Wash. Co. Coroner
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 9/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9/8/69
24c. NAME OF CEMETERY OR CREMATORY: Cambridge, Cemetery
24d. LOCATION (City, town, or county) (State): Cambridge Wash. Idaho

DATE REC'D BY LOCAL REG.: 9-6-69
REGISTRAR'S SIGNATURE: R. Dale Thomason
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E 464

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4426
Local Reg. No. 17
Reg. Dist. No. 320

RECEIVED OCT 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Cambridge
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ralph	Henley	Raymond	9	9	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	married	July 26, 1907	62	1	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: restaurants
11. BIRTHPLACE (State or foreign country): Heath, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul Raymond — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Ida Henley — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 8199
17. INFORMANT'S OWN SIGNATURE: x Louise Parker ADDRESS: Weiser

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Exposure Exposure

DUE TO (c) Auto Accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ✓ SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Washington Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 6 69 7 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto accident

22. *I hereby certify that I attended the deceased from* 9-8- , 1969, *to* 9-9- , 1969 *that I last saw the deceased alive on* 9-9- , 1969, *and that death occurred at* 5:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): M D
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: Sept.9,1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept.12,1969
24c. NAME OF CEMETERY OR CREMATORY: Cambridge, Idaho
24d. LOCATION (City, town, or county): Cambridge (State): Idaho

DATE REC'D BY LOCAL REG.: Sept.9,1969
REGISTRAR'S SIGNATURE: K. Dee Thomson
25. EMBALMER: K. Dee Thomson
LICENSE NO.: E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4427
Local Reg. No. 13
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
SEP 18 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give TOWNSHIP): Weiser
c. LENGTH OF STAY:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Park Haven Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Carrie	May	Watkins	9	11	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	widowed	9/1/1875	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Carthage, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Allen	Illinois	Mary Worthington	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Walter Watkins	Weiser, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chr. failure — 3 wks
DUE TO (c) Arter. Heart D.S — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7/8, 1965, *to* 9/11, 1969 *that I last saw the deceased alive on* 9/10, 1969 *and that death occurred at* 6:32 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Weiser, Idaho	9/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9/13/69	Hillcrest Cemetery	Weiser Wash. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/12/69	[signature]	Marshall S. Dickerson	E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 15 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4428
Local Reg. No. 14
Reg. Dist. No. 320

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ted	G.	Moss	9 14 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	caucasian		5/23/1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seaman	U.S. Coast Guard	Portland, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George B. Moss	-------	Ethel Horner	------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Ethel Louise Thomas by Norma Thomas	Weiser, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Terminal pneumonia	3 wks
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Carcinoma lung	2 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/14, 1969, *to* 9/14, 1969 *that I last saw the deceased alive on* 9/14, 1969 *and that death occurred at* 1020 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
	Weiser, Idaho	9/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9/16/69	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/15/69		Marshall S. Dickerson Jr.	E 464

FIRM NAME Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 7 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4429
Local Reg. No. 15
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington SEP 30 1969
b. CITY OR TOWN: Weiser
c. LENGTH OF STAY: Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION: Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	F.	Fleetwood	9	16	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	married	2/6/1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher	cattle	Unity, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fulton Fleetwood	Baker, Oregon	Virginia Murry	Silver City, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Mrs. Jim Fleetwood by Verna Thomason	Weiser

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Bronchitis — 10 yrs
DUE TO (c) Chr. Emphysema — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/13, 1969, *to* 9/16, 1969, *that I last saw the deceased alive on* 9/16, 1969, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
	Weiser, Idaho	9/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9/19/69	Hillcrest Cemetery	Weiser Wash. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/16/69	L. Lane Thomason	L. Lane Thomason	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 29 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 30 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4430
Local Reg. No. 16
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Wash. 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ontario
d. STREET ADDRESS (If rural, give location): 819 N. Oregon Street

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Edward c. (Last) Melena

4. DATE OF DEATH: (Month) Sept. (Day) 20, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 10, 1890

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Conctractor

10b. KIND OF BUSINESS OR INDUSTRY: Buliding & Homes

11. BIRTHPLACE (State or foreign country): Niobrara, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joseph Melena — BIRTHPLACE: Ceckoslavokia

14. MOTHER'S MAIDEN NAME: Marie Tourek — BIRTHPLACE: Ceckoslavokia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 501-05-3772A

17. INFORMANT'S OWN SIGNATURE: Melena Melena — ADDRESS: Ontario

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) R.T. H.T. Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hematuria, Etio. unk.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/20, 1969, *to* 9/20, 1969, *that I last saw the deceased alive on* 9/20 1969 *and that death occurred at* 10:40 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Weiser Idaho

23c. DATE SIGNED: Sept. 20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-24-1969

24c. NAME OF CEMETERY OR CREMATORY: Olney Cemetery

24d. LOCATION (City, town, or county) (State): Pendleton, Oregon

DATE REC'D BY LOCAL REG.: 9-30-69

REGISTRAR'S SIGNATURE: T. Dee Thomson

25. EMBALMER: Robert J. Bertelsen

LICENSE NO.: One. 222

FIRM NAME: Bertelson-Liemkaemper

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 7 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4431
Local Reg. No. 18
Reg. Dist. No. 320

BIRTH NO. 69-9703

Certificate of Death

RECEIVED STATE OF IDAHO

OCT 6 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Weiser
c. LENGTH OF STAY IN THIS PLACE:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Javier	-----	Carrazico Jr.	9	23	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	Mexican	never married	9/23/09				7	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Weiser, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Javier Carrazico	Eagle Pass, Tex.	Rosa Carvagal	Eagle Pass, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): infant
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Javier Carrazico ADDRESS: Weiser, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Premature (5mo ±)	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Premature Separation	
DUE TO (c)	Of Placenta	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-23- , 1969, *to* 9-23- , 1969, *that I last saw the deceased alive on* 9-23- , 1969, *and that death occurred at* 10:50 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D. McGeath M.D.	Weiser, Idaho	9/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9-25-69	Hillcrest Cemetery	Weiser Washington Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/23/69	L. Dee Thomason	L. Dee Thomason	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED OCT 15 1969 STATE OF IDAHO

State File No. 4432
Local Reg. No. 19
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 335 W. Main

3. NAME OF DECEASED (Type or Print): a. (First) CLYDE; b. (Middle); c. (Last) WILSON

4. DATE OF DEATH: (Month) Sept. (Day) 26 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept.9, 1885

9. AGE (In years last birthday): 84 | IF UNDER 1 YEAR Months | Days: 17 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Dealer

10b. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (State or foreign country): Clarenda, Iowa

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Joe Wilson
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Mary Ellen Turner
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-36-1823

17. INFORMANT'S OWN SIGNATURE: Jackie Jackson
ADDRESS: Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): C. V. A.
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): Gen Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing it.
Uremia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-25- *, 19*69*, to* 9-26- *, 19*69*, that I last saw the deceased alive on* 9-26- *, 19*69*, and that death occurred at* 3:10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm. D. McGeath MD

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: Sept.26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept.29,1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: Sept.26,1969

REGISTRAR'S SIGNATURE: T. Dan Thomson

25. EMBALMER: Marshall S. Dickerson

LICENSE NO.: E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4433
Local Reg. No. 821
Reg. Dist. No. 370

BIRTH NO. 69-9716

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Boise
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho City
d. STREET ADDRESS (If rural, give location): P. O. Box 123

3. NAME OF DECEASED (Type or Print)
a. (First): SUSAN
b. (Middle):
c. (Last): HARRIS

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant

8. DATE OF BIRTH: Sept. 18, 1969

9. AGE (In years last birthday): IF UNDER 1 YR. Months / Days: 1 | IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jerry D. Harris
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Ramona Velasquez
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Jerry D Harris
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Anoxia, Central	10 Hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Circulatory failure	12 Hrs
DUE TO (c)	Uterine Rupture, Maternal	12 Hrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

7684

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9/18, 1969, *to* 9/18, 1969, *that I last saw the deceased alive on* 9/18, 1969, *and that death occurred at* 2:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Boise, Ida
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/24/69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise,
(State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 12, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters [signature]
LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4434
Local Reg. No. 814
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Emerson
b. (Middle): Emery
c. (Last): Haines

4. DATE OF DEATH (Month) 9 (Day) 28 (Year) 1969

5. SEX: male
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: 4/11/1905
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: agriculture
11. BIRTHPLACE (State or foreign country): Loup City, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Chris Haines — BIRTHPLACE: -----
14. MOTHER'S MAIDEN NAME: Rebecca May Keller — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 2
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Roy D. Haines — ADDRESS: Cambridge

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Aortic graft for obstruction ?5 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/28/69 4:00 AM, 19__, *to* 9/28/69 8:30 AM, 19__, *that I last saw the deceased alive on* 9/28/69, 19__, *and that death occurred at* 8:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard A. Forney, M.D. — 171 — R. A. Forney MD
23b. ADDRESS: 425 W. Bannock Boise, Idaho
23c. DATE SIGNED: 9/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): rem. burial
24b. DATE: 10/3/69
24c. NAME OF CEMETERY OR CREMATORY: Loup City Cemetery
24d. LOCATION (City, town, or county) (State): Loup City, Nebraska

DATE REC'D BY LOCAL REG.: Nov. 10 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: R. Dan Thomason
LICENSE NO.: E 388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 13 1969
JAN 14 1970
FEB 13 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to obtain the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4435
Local Reg. No. 649
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011 OCT 15 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE Bureau of Vital Statistics

c. LENGTH OF STAY (In this place)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST LUKE'S HOSPITAL (DOA) 002

d. STREET ADDRESS (If rural, give location) 1619 No. 9th

3. NAME OF DECEASED (Type or Print) a. (First) BETTY b. (Middle) E. c. (Last) RICHARDSON

4. DATE OF DEATH (Month) (Day) (Year) October 1, 1969

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH 3-25-1901

9. AGE (In years last birthday) 68 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cabo, Missouri

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Charles W. Stillwell BIRTHPLACE Carthage, Missouri

14. MOTHER'S MAIDEN NAME Ethel Rogers BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 22 6564

17. INFORMANT'S OWN SIGNATURE Conway Grant - Family records ADDRESS

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Donald Schwach 318 (Degree or title) MD

23b. ADDRESS 401 No Orchard Boise Ohio

23c. DATE SIGNED 10-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 6, 1969

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Oct. 13, 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Eldon T. Pearson

LICENSE NO. E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED OCT 13 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4436
Local Reg. No. 644
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 8 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 23	d. STREET ADDRESS (If rural, give location): 2407 Regan St.

3. NAME OF DECEASED (Type or Print) a. (First): Earl	b. (Middle): C.	c. (Last): Timmel	4. DATE OF DEATH (Month) (Day) (Year): October 1, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Oct. 6, 1886	9. AGE (In years last birthday): 82; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Garage Man 21	10b. KIND OF BUSINESS OR INDUSTRY: Automobile	11. BIRTHPLACE (State or foreign country): Nebraska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William Timmel	BIRTHPLACE: Ohio	14. MOTHER'S MAIDEN NAME: Virginia Moran	BIRTHPLACE: West Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: 519-01-1363A	17. INFORMANT'S OWN SIGNATURE: Selma Timmel	ADDRESS: 2407 Regan Boise, Idaho	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-8-69, 19__, *to* 10-1-69, 19__, *that I last saw the deceased alive on* 10-1-69, 19__, *and that death occurred at* 8:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: X [signature] 395 (Degree or title) MD.	23b. ADDRESS: 403 Idaho Boise, Idaho	23c. DATE SIGNED: 10-6-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct. 4, 1969	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill	24d. LOCATION (City, town, or county): Boise, (State): Idaho
DATE REC'D BY LOCAL REG.: Oct. 13, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Robert G. Ross	LICENSE NO.: E-497

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Summers Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 13 1969

OCT 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 19 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. Jeppesen
Ada State 342-8221

Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

State File No. 4437
Local Reg. No. 643
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho	c. LENGTH OF STAY (In this place): 10 years
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2233 Columbus St. 000	d. STREET ADDRESS (If rural, give location): 2233 Columbus St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Arthur	Frederick	Guntly	10 2 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
Male	White	Married	9-10-1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction Superintendant	Same	Turin, Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur Guntly Sr.	Michigan	Clara Thatcher	Toledo, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		379-09-4072	Stanley A. Guntly	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

185X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of prostate — INTERVAL BETWEEN ONSET AND DEATH: 9 + yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12-1-67	Cancer of prostate	Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 26, 1967, *to* Oct 2, 1969, *that I last saw the deceased alive on* Oct 2, 1969, *and that death occurred at* 2 or 9 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred Jeppesen 259	M.D.	Boise Idaho	10/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-4-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 10 1969	Myrtle Palmer	Erle B. Byram	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 14 1969
OCT 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 27 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
OCT 10 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4438
Local Reg. No. 130
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Boise c. LENGTH OF STAY (In this place): yrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3621 No. Patricia Lane	d. STREET ADDRESS (If rural, give location): 3621 No. Patricia Lane

3. NAME OF DECEASED (Type or Print) a. (First): RAY	b. (Middle):	c. (Last): MARKS	4. DATE OF DEATH (Month) (Day) (Year): October 2, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Feb. 14, 1904.	9. AGE (In years last birthday): 65 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY: Agriculture	11. BIRTHPLACE (State or foreign country): Asotin County, Wash.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: J. D. Marks	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Susan Anne Bright	BIRTHPLACE: Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 535-09-1317	17. INFORMANT'S OWN SIGNATURE: Edna C. Marks	ADDRESS: Boise, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Antimesenteric Vessels Dam — Not Known
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/2/69, 19__, *to* 10/2/69, 19__, *that I last saw the deceased alive on* 10/2/69, 19__, *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title)	23b. ADDRESS: 1703 Hill Road, Boise	23c. DATE SIGNED: 10/6/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10/6/69	24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Gardens	24d. LOCATION (City, town, or county) (State): Canyon Co., Nampa, Idaho
DATE REC'D BY LOCAL REG.: Oct. 9, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Marvin R. [signature]	LICENSE NO.: 515

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4439
Local Reg. No. 656
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Oregon
b. COUNTY: Union
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Union
d. STREET ADDRESS (If rural, give location): 953 No. Gale Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EARL	LAMAR	POWELL	Oct. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 29, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
/?		Clayton, Georgia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marvin Alvin Powell	No Record	Nany Abbott	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	542-07-0884	Conway Grant/Hospital Records	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5310

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Gastric ulcer & hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of the rectum — 6 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept. 9, 1969 *to* Oct. 2, 1969 *that I last saw the deceased alive on* Oct 2, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Elmer E. Talley MD	125 E. Main	10/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct. 3, 1969	Union Cemetery	Union, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 15, 1969	Myrtle Palmer	Eldon T. Pearson	E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 15 1969

Bureau of Vital Statistics

State File No. 4440
Local Reg. No. 651
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY in this place: Life
d. FULL NAME OF HOSPITAL OR INSTITUTION: 109 North 17th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: ADa
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 109 North 17th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Carlton		Abercrombie	10	3	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Nov 17, 1886	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cement Contruction	Construction	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Y.H. Abercrombie	Georgia	Alice Lindsey	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-01-2880	Don Abercrombie	Ogden, Utah

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Treatements by two Dr's for Heart Condition. — Weeks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 10P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise	10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-8-69	Morriss Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 14, 1969	Myrtle Palmer	[signature]	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 06 2009

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician:.....

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RECEIVED

BIRTH NO OCT 13 1969

Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4441
Local Reg. No. 645
Reg. Dist. No. 370

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 43 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6905 Randolph Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALAN	D.	CAMERON	Oct. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 20, 1917	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attorney	Federal Gov.	Chicago, Illinois	USA

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
Ossian Cameron, Montreal, Canada	Rose Gilbertz, Stockholm, Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE — ADDRESS
Yes WW II	525-20-4879	Joshua K Cameron 6905 Randolph Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma Rt Kidney — INTERVAL BETWEEN ONSET AND DEATH: More than 2 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): —
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Extensive Metastases

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* — , 1965 *to* Oct. 3, 1969, *that I last saw the deceased alive on* Oct 3, 1969, *and that death occurred at* 11:00 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Krayer, M.D.	Boise Idaho	Oct. 7 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-7-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13 1969	Myrtle Palmer	Lowell L Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 13 1969
OCT 16 1969
OCT 22 1969
NOV 12 1969
NOV 19 1969
DEC 10 1969
MAR 1 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4442
Local Reg. No. 127
Reg. Dist. No. 371

BIRTH NO.

RECEIVED OCT 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1419 BROADWAY

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEWIS	(NMI)	ROBERTS	OCTOBER 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	10-27-93	75	— / —	— / —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CIVIL ENGINEER	SAME	WELLINGTON, KANSAS	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
CHARLES L. ROBERTS	OHIO	ETTA MAE ROUSE	OHIO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWI	519-24-50-18	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Terminal Bronchopneumonia	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized atherosclerosis with chronic brain syndrome	several yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I VA attended the deceased from OCTOBER 2, 19 69, to OCTOBER 3, 19 69, and that death occurred at 1:57p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. G. RIML, M.D. [signature]	VA CENTER, BOISE, IDAHO	10-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-6-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 8, 1969	Myrtle Palmer	Everett B. Bynum	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 18 2000 OCT 15 1969

JUL 26 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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69-9755

BIRTH NO.

Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 22 1969

Bureau of Vital Statistics

State File No. 4443
Local Reg. No. 664
Reg. Dist. No. 370

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): one day

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Iaho
b. COUNTY: Ada Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital
d. STREET ADDRESS (If rural, give location): 7201 Ashland Dr.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Gary	James	Minor Jr.	10	4	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	10-3-69		1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Newborn(Infant)	Newborn (Infant)	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gary James Minor	Oregon City, Oregon	Merddith Faye McNiece	Calf.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	Newborn (Infant)	Mary James Minor	Boise Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Premature birth — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature rupture of membrane — 8-12 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prolapsed cord

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. E. Gibson	MD	Boise, Idaho	10/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-8-69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 21 1969	Myrtle Palmer	Eric B. Byram	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4444
Local Reg. No. 642
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (In this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5535 Randolph Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 5535 Randolph Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Katherine	Marie	Bates	Oct. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 20, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Clayton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David H. Horton	Michigan	Unknown	Challis, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	----------		X Dane N. Horton	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Not Determined.

INTERVAL BETWEEN ONSET AND DEATH: Brief

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See, to A. Live., 19____, *that I last saw the deceased alive on* ____, 19____ *and that death occurred at* 10P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise	10-10-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Cremation	10-11-1969	Mtn. View Crematory	Boise, Idaho	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 10 1969	Myrtle Palmer	Daniel G. Gibson	E-400

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 10 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4445
Local Reg. No. 639
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 04	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place): 2 Months
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 6818 Fairfield

3. NAME OF DECEASED (Type or Print) a. (First): FOSTER	b. (Middle): W.	c. (Last): LIVINGSTON	4. DATE OF DEATH (Month) (Day) (Year): OCT. 5, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced	8. DATE OF BIRTH: Dec. 6, 1909	9. AGE (In years last birthday): 59 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Florist 21	10b. KIND OF BUSINESS OR INDUSTRY: Floral	11. BIRTHPLACE (State or foreign country): York, Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Charles W. Livingston	BIRTHPLACE: Pennsylvania	14. MOTHER'S MAIDEN NAME: Edith May Schauck	BIRTHPLACE: Pennsylvania	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: 516-05-7872	17. INFORMANT'S OWN SIGNATURE: + Edith S. Francone	ADDRESS: 6818 Fairfield Boise, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1419

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): CARCINOMA OF TONGUE — INTERVAL BETWEEN ONSET AND DEATH: 15 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MARCH 15, 1969, *to* Oct. 5, 1969, *that I last saw the deceased alive on* Oct. 1, 1969, *and that death occurred at* 1:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE: M M Rubholder, MD 011 (Degree or title)	23b. ADDRESS: 848 La Cassia, Boise	23c. DATE SIGNED: 10-7-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct. 9, 1969	24c. NAME OF CEMETERY OR CREMATORY: Highland Cemetery	24d. LOCATION (City, town, or county) (State): Great Falls, Montana
DATE REC'D BY LOCAL REG.: Oct. 9, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Gary A. Cowger	LICENSE NO.: E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 10 1969
OCT 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

SEP 11 1986

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4446
Local Reg. No. 660
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): TREASURE VALLEY MANOR 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1708 North 8th

3. NAME OF DECEASED (Type or Print): a. (First) STELLA b. (Middle) M. c. (Last) PACKER SMITH

4. DATE OF DEATH (Month) (Day) (Year): October 5, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Nov. 17, 1898

9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Designer

10b. KIND OF BUSINESS OR INDUSTRY: Floral Shop

11. BIRTHPLACE (State or foreign country): LaSalle, Colorado

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Eddy G. Packer
BIRTHPLACE: DesMoines, Iowa

14. MOTHER'S MAIDEN NAME: Ida M. Reeves
BIRTHPLACE: Seney, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 40 2416A

17. INFORMANT'S OWN SIGNATURE: X [signature]
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

403X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Nephrosclerosis - Severe

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1965, to Oct, 1969, that I last saw the deceased alive on Oct 1, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE: C. G. Johnson 261 (Degree or title): MD

23b. ADDRESS: Boise Ida

23c. DATE SIGNED: 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 9, 1969

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Oct. 20, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant

LICENSE NO.: E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 4447
Local Reg. No. 132
Reg. Dist. No. 371

BIRTH NO.

OCT 13 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): HIGHWAY 30, ONE MILE EAST OF MERIDIAN
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HIGHWAY ACCIDENT

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 8228 POPLAR ST.

3. NAME OF DECEASED (Type or Print): a. (First) ZELDA b. (Middle) A. (VIOLET) c. (Last) STRIBLING
4. DATE OF DEATH (Month) (Day) (Year): OCT. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	WIDOWED	NOV 8, 1908	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Wharton, Texas	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elmer Alston	Stockdale, Texas	Elizabeth Cone	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	452 34 0826	X Melba Smith	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8129

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiply Head-Brain Injuries.

INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Ida			13010

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
10	5	69	820P m.		Auto Collision on Hiway, Near Meridian. Ida;

22. *I hereby certify that I attended the deceased from* Dic Not, 19 See to Alive, 19, *that I last saw the deceased alive on* , 19, *and that death occurred at* 820P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. D. Paris Coroner	3720 Meadow Drive. Boise.	10-11-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 8, 1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 13 1969	Myrtle Palmer	Conway Grant	IE478

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM OH-63021

OCT 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4448
Local Reg. No. 134
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA OCT 15 1969

Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE

c. LENGTH OF STAY (In this place) 2 DAYS

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) ROUTE 5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FORREST	V.	PATTON	OCTOBER 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	JULY 5, 1910	59	— / —	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
COOK	SAME	ELSBERRY, MISSOURI	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
CLAUDE PATTON	MISSOURI	ADDIE WATTS	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII	329-01-9486	Ernest Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

3479

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia, bilateral. — INTERVAL BETWEEN ONSET AND DEATH: Terminal

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic progressive central nervous system disease of undetermined cause. — q 20 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute pyelonephritis, right. — Unknown.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22 VA attended the deceased from OCTOBER 4, 19 69, to OCTOBER 6, 19 69, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.G. STROMBERG, M.D.		VA CENTER, BOISE, IDAHO	10-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	10-9-69	Cloverdale Memorial Park	Boise,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 14 1969	Myrtle Palmer	Clyde Vassar	E535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 17 1969 Bureau of Vital Statistics

State File No. 4449
Local Reg. No. 655
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA St Luke'S Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3403 No. 39th

3. NAME OF DECEASED (Type or Print): a. (First) HENRY b. (Middle) F. c. (Last) REED

4. DATE OF DEATH: (Month) Oct. (Day) 6, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 3, 1917

9. AGE (In years last birthday): 52
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer 10

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Grand Fork's, N.D.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Calvin Reed
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Wilhelmina Gotzan
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 502 09 4505

17. INFORMANT'S OWN SIGNATURE: x Steven F. Reed
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [x] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] (Degree or Title) 35

23b. ADDRESS: [illegible] Ada

23c. DATE SIGNED: 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 10, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rosedale

24d. LOCATION (City, town, or county) (State): Payette, Idaho

DATE REC'D BY LOCAL REG.: Oct. 16 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant

LICENSE NO.: E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 20 1969
OCT 29 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
JUL 22 1976
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
FEB 22 1999
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4450
Local Reg. No. 646
Reg. Dist. No. 370

RECEIVED OCT 13 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1910 Hill Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RAYMOND	G.	RINEHART	Oct. 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct. 13, 1890	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Rancher	Cattle	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles H. Rinehart	Oregon	Maggie Pigg	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-10-7304	Mary A Rinehart	1910 Hill Rd. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Congestive Heart Failure - Decompensated	6 mos
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Vascular Disease	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

4409

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5/6/66, 19__, to 10/6/69, 19__, that I last saw the deceased alive on 10/6/69, 19__, and that death occurred at 11:50a.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	1023 Hill Road	10/9

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 9, 1969	Glenn Rest Cemetery	Glenns Ferry Elmore Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13, 1969	Myrtle Palmer	Robert G. Ross	E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 13 1969

OCT 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 7 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 05 1988

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr Reynolds

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4451
Local Reg. No. 641
Reg. Dist. No. 370

BIRTH NO.

OCT 10 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 1 Week	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): Route #3 Meridian

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ruby	E.	Acorda	10	7	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Jan.16, 1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Same	Avera Georgia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edagar Hadden	Georgia	Susie Bell Newsome	Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		530-20-7508	John V. Acorda	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

180X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer of Cervix Uteri — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H.E. Ardman 137	M.D.	Boise, Ida	10/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-11-69	Carlin Cemetery	Carlin, Nevada

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 9 1969	Myrtle Palmer	Eric B. Bingham	E=533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4452
Local Reg. No. 647
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — OCT 13 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 102 Village Lane

3. NAME OF DECEASED (Type or Print)
a. (First): Josephine
b. (Middle): Also known as Josie Cora
c. (Last): Holton Holton

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 23, 1900
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Milliner 21
10b. KIND OF BUSINESS OR INDUSTRY: Retail Dept. Store
11. BIRTHPLACE (State or foreign country): Red Lodge, Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Edgar Lloyd — BIRTHPLACE: Virginia City, VA.
14. MOTHER'S MAIDEN NAME: Jennie Cowan — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-34-3403
17. INFORMANT'S OWN SIGNATURE: X Mrs. Carl [illegible] — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

428X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Undetermined (biopsy still being processed).
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Nephritis — about 1 year

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 Oct., '69, 1969, *to* 7 Oct., 1969, *that I last saw the deceased alive on* 6 Oct., 1969, *and that death occurred at* 4:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Lyle Stones 505 (Degree or title) — Lyle Stones, M.D.
23b. ADDRESS: 220 N. 1st St., Boise, Idaho
23c. DATE SIGNED: 10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/9/1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 13, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Paul Waggoner — LICENSE NO.: E-422

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alden-Waggoner Chapel

DUTIES:

OCT 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 26 1995

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4453
Local Reg. No. 650
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 15 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 22 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home at 1323 Howard Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1323 Howard Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Claud	R.	Williamson	Oct. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 5, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Truck Driver 093	Ada County	Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clay Williamson	Kansas	Ladessie Hoag	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-36-2392	x Eleanor Williamson	1323 Howard St. Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Epidermoid Carcinoma	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	of Lung	16 Mo.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4/29, 68, to Oct 7, 69, *that I last saw the deceased alive on* 9-10, 69, *and that death occurred at* 12:45a.m. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John E. Coppard 094	MD	311 Idaho St	10-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 10, 1969	Dry Creek	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13, 1969	Myrtle Palmer	Robert G. Ross	E 497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

FEB 2 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4454
Local Reg. No. 770
Reg. Dist. No. 370

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011 OCT 27 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place):
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 718 So. Washington

3. NAME OF DECEASED (Type or Print) a. (First): Michael	b. (Middle): Adrian	c. (Last): McCullough	4. DATE OF DEATH (Month) (Day) (Year): Oct. 9, 1969	
5. SEX: males	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married	8. DATE OF BIRTH: October 8, 1969	9. AGE (In years last birthday): IF UNDER 1 YR. Months / Days 1; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child 02	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Parks N. McCullough	BIRTHPLACE: Windsor, Colo.	14. MOTHER'S MAIDEN NAME: Leilla Jane Bowen	BIRTHPLACE: Mindon, Neb.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT'S OWN SIGNATURE: X Parks McCullough Jr	ADDRESS:	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7759

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Erythroblastosis Fetalis with hydrops

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* birth *, 19___, to* death *, 19___, that I last saw the deceased alive on* 10/8 *, 19*69*, and that death occurred at* 9:25 a *m., from the causes and on the date stated above.*

23a. SIGNATURE: W L Venning 542 (Degree or title): MD	23b. ADDRESS: Boise	23c. DATE SIGNED: 10/14/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): burial	24b. DATE: Oct. 14, 1969	24c. NAME OF CEMETERY OR CREMATORY: Emmett Cemetery	24d. LOCATION (City, town, or county) (State): Emmett, Idaho
DATE REC'D BY LOCAL REG.: Oct. 24, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Glenn W Beatty	LICENSE NO.: E392

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 2 0 1999

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

State File No. 4455
Local Reg. No. 648
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 005

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3223 North 36th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROBERT	LINN	WARNER	Oct 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 9, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Watchman - Veterans Administration
10b. KIND OF BUSINESS OR INDUSTRY: 05
11. BIRTHPLACE (State or foreign country): Adrian, Mich.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roy B. Warner	Michigan	Lois A. Tripp	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 390-10-7015
17. INFORMANT'S OWN SIGNATURE: 3223 N. 36th ADDRESS
x Genevieve Warner, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Diabetic Seizure, with Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
Not Determined.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19 , that I last saw the deceased alive on , 19 , and that death occurred at 630A m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
C. O. Evans 583 (Degree or title) Coroner	3720 Meadow Drive, Boise, (State)	10-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)
Burial	10-11-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13, 1969	Myrtle Palmer	[signature]	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 13 1969

OCT 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 5 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JAN 21 1970
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4456
Local Reg. No. 657
Reg. Dist. No. 370

BIRTH NO.

OCT 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise,	c. LENGTH OF STAY (Not this place) 20 years
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Valley Con. Home 337	d. STREET ADDRESS (If rural, give location) 6216 Robertson Dr.

3. NAME OF DECEASED (Type or Print)	a. (First) George	b. (Middle) William	c. (Last) Knowles Sr.	4. DATE OF DEATH (Month) 10 (Day) 10 (Year) 69
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 13, 1881	9. AGE (In years last birthday) 88 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer 08	10b. KIND OF BUSINESS OR INDUSTRY County Civil Eng.	11. BIRTHPLACE (State or foreign country) Logan, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Knowles	BIRTHPLACE Clay Co. Neb.	14. MOTHER'S MAIDEN NAME Laura Baugh	BIRTHPLACE Birmingham, Engla	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE X George W. Knowles Jr.	ADDRESS Boise	

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Emphysema, Chorn 22

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-2, 1969, *to* 10-10, 1969, *that I last saw the deceased alive on* 10-10, 1969, *and that death occurred at* 6:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE James G Happy and Mil 089 (Degree or title)	23b. ADDRESS 48W Fairview Boise	23c. DATE SIGNED 10-14-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-13-69	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho		
DATE REC'D BY LOCAL REG. Oct. 17 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Ed B. Byram
LICENSE NO. E-533		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4457
Local Reg. No. 136
Reg. Dist. No. 271

BIRTH NO.

RECEIVED
OCT 22 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: 211 E. 39th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN: Boise
d. STREET ADDRESS (If rural, give location): 211 E. 39th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	Francis	Root	Oct. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Jan. 19, 1915	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter & Cement Finisher	Const.	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry F Root	Minnesota	Florence May Fenrich	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-30=0690	Henry F. Root Jr.	

MEDICAL CERTIFICATION

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. History of coronary disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY--DID NOT SEE ALIVE *19___, to ___, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at* 6P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
0583 Coroner 4		3720 Meadow Dr., Boise, Idaho	10/17/1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/18/1969	Fargo Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 21 1969	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: Alden Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: DEC 11 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4458
Local Reg. No. 658
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 21 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 808 N. Curtis Rd.

3. NAME OF DECEASED (Type or Print)
a. (First): Elizabeth
b. (Middle): Ann
c. (Last): Smothers

4. DATE OF DEATH (Month) (Day) (Year): Oct. 11, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 15, 1879

9. AGE (In years last birthday): 90
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Lovilla, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael McConnell
BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Malissa Ann Cooper
BIRTHPLACE: McConnell, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 545-30-6216

17. INFORMANT'S OWN SIGNATURE: Mrs V. F. Klinefelter
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Senile psychosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): General arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Malnutrition

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 8, 1968, *to* Oct. 11, 1969, *that I last saw the deceased alive on* Oct. 9, 1969, *and that death occurred at* 7:30 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Howard E. Allen 005 (Degree or title): M.D.
23b. ADDRESS: 220 N. 1st St., Boise, Idaho
23c. DATE SIGNED: 10/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/14/1969
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Oct. 17 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Paul Waggoner
LICENSE NO.: E-422
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4459
Local Reg. No. 659
Reg. Dist. No. 370

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1001 Huston Rd.

3. NAME OF DECEASED (Type or Print)
a. (First): Olga
b. (Middle): I
c. (Last): Streeter

4. DATE OF DEATH (Month) (Day) (Year): October 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 8, 1890
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Milliner - Ret. 21
10b. KIND OF BUSINESS OR INDUSTRY: retail
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles A. Luce — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Amanda E. Crew — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 553-32-5059
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: 2808 Fry St. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): BREAST CANCER — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-20, 1965, *to* 10-7, 1969, *that I last saw the deceased alive on* 10-7, 1969, *and that death occurred at* 10:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice M. Rubinholder, MD
23b. ADDRESS: 848 La Cassia, Boise
23c. DATE SIGNED: 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 10-16-69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Boise

DATE REC'D BY LOCAL REG.: Oct. 17 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-527

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Mountain View Funeral Home, Boise

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4460
Local Reg. No. 652
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 17 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2½ months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convelesent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1923 North 9th Street

3. NAME OF DECEASED (Type or Print): a. (First) Edith b. (Middle) Ellen c. (Last) Cardin

4. DATE OF DEATH: (Month) (Day) (Year) October 13, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: February 2, 1887

9. AGE (In years last birthday): 82
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School teacher

10b. KIND OF BUSINESS OR INDUSTRY: Teaching

11. BIRTHPLACE (State or foreign country): Woodlake, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: W.R. Klingaman
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Sarah Kent
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-44-5613

17. INFORMANT'S OWN SIGNATURE: Edith M Dennett
ADDRESS: 6818 W. State Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Dis
DUE TO (c): Senile Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February, 1962 to 13 October, 1969, that I last saw the deceased alive on 13 October, 1969, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): George R Baker, MD

23b. ADDRESS: GEORGE R. BAKER, M.D. 121 EAST IDAHO STREET BOISE, IDAHO 83702

23c. DATE SIGNED: 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 15, 1969

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Oct. 16, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Harry A. Conover

LICENSE NO.: E-526

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM OH-63021

OCT 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4461
Local Reg. No. 669
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 01	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Boise	c. LENGTH OF STAY (In this place) mins.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location) Rt. # 2 S. Five Mile Rd.

3. NAME OF DECEASED (Type or Print) a. (First) JAMES	b. (Middle) L.	c. (Last) EDMONDS	4. DATE OF DEATH (Month) (Day) (Year) Oct. 13, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 4, 1925	9. AGE (In years last birthday) 44 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber 21	10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (State or foreign country) Smith Center, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Edmonds	BIRTHPLACE Missouri	14. MOTHER'S MAIDEN NAME Mabel Zade	BIRTHPLACE Kansas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) WWII	16. SOCIAL SECURITY NO. 519-16-8960	17. INFORMANT'S OWN SIGNATURE X Genevieve Edmonds	ADDRESS

916X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed Chest

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bilateral rib fractures.
DUE TO (c) Cave-in accident

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Subarachnoid hemorrhage Aortic laceration, hemo-pneumo-thorax. Fx. mandible

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Street 28	21c. (CITY, TOWN, OR TOWNSHIP) Boise	(COUNTY) 011 ADA (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 13 1969 3:00 p.m.	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? Cave-in Ditch.	

22. *I hereby certify that I attended the deceased from* 4:15 13 Oct 1969, *to* 6:00 pm 13 Oct 1969, *that I last saw the deceased alive on* 13 Oct, 1969, *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert E. Montgomery MD (Degree or title)	23b. ADDRESS 2121 College Blvd	23c. DATE SIGNED 20 Oct.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-16-69	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park	24d. LOCATION (City, town, or county) Boise, (State) Idaho
DATE REC'D BY LOCAL REG. Oct. 24, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER G. W. Waters G W Waters	LICENSE NO. E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 4 1969

OCT 3 0 1969

MAY 18 2004

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 31 1969
Bureau of Vital Statistics

State File No. 4462
Local Reg. No. 785
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Boise
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Garden Valley
d. STREET ADDRESS (If rural, give location): Star Route, Banks

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LYMAN	MOSIAH	FACKRELL	October 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married	April 18, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ice Deliveryman	Ice Co. Mfg.	Orederville, Utah	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Sumner Fackrell	Bountiful, Utah	Margaret Clarissa Hancock	Payson, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518 07 4550A	X Audrey L. Fackrell	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Caranoma of Bladder 188X — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from October 11, 1969, to October 13, 1969, that I last saw the deceased alive on October 13, 1969 and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F B Jeppesen 259	M D	124 State Boise Idaho	10/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 16, 1969	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 29, 1969	Myrtle Holmes	Conway Grant	E478

FIRM NAME: Kelyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4463
Local Reg. No. 185
Reg. Dist. No. 371

BIRTH NO.

RECEIVED OCT 17 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 27 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 702 HAYS

3. NAME OF DECEASED (Type or Print): a. (First) WILSON; b. (Middle) (NONE); c. (Last) MOORE

4. DATE OF DEATH: (Month) OCTOBER (Day) 13, (Year) 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED

8. DATE OF BIRTH: SEPT. 20, 1926

9. AGE (In years last birthday): 43
IF UNDER 1 YR. Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BARTENDER 23

10b. KIND OF BUSINESS OR INDUSTRY: SAME

11. BIRTHPLACE (State or foreign country): NAUVOO, MISSOURI

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM MOORE — BIRTHPLACE: MISSOURI

14. MOTHER'S MAIDEN NAME: MARY A. PARKS — BIRTHPLACE: MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 519 22 22 29

17. INFORMANT'S OWN SIGNATURE: James Bentley — ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5719

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cirrhosis of liver. — INTERVAL BETWEEN ONSET AND DEATH: Unknown.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hepato-renal syndrome. — 3 weeks.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* SEPTEMBER 16, 19 69, to OCTOBER 13, 19 69 [redacted], *and that death occurred at* 10:05p m., *from the causes and on the date stated above.*

23a. SIGNATURE: FRED B. HINE, M.D. Fred B. Hine, MD (Degree or title)

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 10/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 17, 1969

24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: Oct. 16, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Howell Summers

LICENSE NO.: E-509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 22 1969
Bureau of Vital Statistics

State File No. 4464
Local Reg. No. 666
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 2 WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION Restful Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 614 So. Washington

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Richard	Adolph	Thome	Oct. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years if 1st birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Feb. 16, 1881	88	7 / 17	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer	fruit	Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Thome	Germany	Laura Farber	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		541-28-0914A	Emma A Thome	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis
Anemia - Cause Undetermined

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9-23, 1969, to 10-10, 1969, that I last saw the deceased alive on 10-13, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. C. Munson	MD	Boise Ida	10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 16, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 21 1969	Myrtle Palmer	Glenn W Beatty	E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4465
Local Reg. No. 653
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 1 5 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital
d. STREET ADDRESS (If rural, give location): 319 East 40th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VERNAL	E.	KELLER	Oct. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 13, 1917	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Police Officer	Police	Rigby, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Youe Keller	Unknown	Nora Gilson	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519-07-4457	Douglas Keller	319 E. 40th St. Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Did have severe attack about 4 years ago.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, that I last saw the deceased alive on ____, and that death occurred at* 1:40a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise,	10-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 18, 1969	Dry Creek	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 16, 1969	Myrtle Palmer	[signature]	E-526

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

MAY 0 2 2014 OCT 1 6 1969

NOV 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 30 1969 Bureau of Vital Statistics

State File No. 4466
Local Reg. No. 779
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian rural
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Orpha	M.	Baldwin	Oct. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Oct. 3, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Lucerne, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elija G. Amak	Unk.	Mary E. Young	Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Paul Baldwin	Kuna

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	3 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Debilitation	2 weeks
DUE TO (c)	Congestive heart failure	3 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerebral Syndrome +	3 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-30 , 19 65 *to* death , 19 69 , *that I last saw the deceased alive on* 14 Oct 69 , 19 , *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lee H. Culley 624	MD	925 E 1st Meridian	10 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-18-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 28 1969	Myrtle Palmer	Reserved	E-366

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 3 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4467
Local Reg. No. 24
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 21 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 203

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 904 N. 16th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Walter	Garfield	Cook	Oct. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Jan. 24, 1882	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk 25	1st Security Bank	Maryville, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lorenzo Dow Cook	New York	Mary Jane Dunnigan	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-12-7043	Mrs. Walter H Cook	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arterio sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Severe Generalized Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 10-11, 1969, *to* 10-15, 1969, *that I last saw the deceased alive on* 10-15, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C C Thurson 241 MD	Boise Ida	10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/18/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 21, 1969	Myrtle Palmer	Hazel Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 21 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4468
Local Reg. No. 662
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 — OCT 21 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau of V

c. LENGTH OF STAY (In this place)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 600 Logan

d. STREET ADDRESS (If rural, give location) 600 Logan

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Olive	Newman	Marshall	Oct. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
female	White	Divorced	June 10, 1904	65	4	5		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 28		Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Olaf E. Newman	Ortrask, Sweden	Margaret L. B Palmer	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Marilyn J Marshall Attic	1233 W 61st Apt 10 Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Coronary

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April, 1965, to _____, 19____, that I last saw the deceased alive on Sept, 1969, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bruce Mordy	MD	2429 N Cole Rd	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 18, 1969	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 21, 1969	Myrtle Palmer	Daniel G. Gibson	400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 21 1969
SEP 23 1992

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECE[illegible]

State File No. 4469
Local Reg. No. 665
Reg. Dist. No. 370

BIRTH NO.

OCT 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Treasure Valley Manor 293	d. STREET ADDRESS (If rural, give location) 6620 Morton Drive

3. NAME OF DECEASED (Type or Print) a. (First) Elsie	b. (Middle) Emmaline	c. (Last) Ames	4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 16, 1874	9. AGE (In years last birthday) 94; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Manhatton, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry C. Crump	BIRTHPLACE Jonesville, Ind.	14. MOTHER'S MAIDEN NAME Catherine Ann Webber	BIRTHPLACE Delaware, Ohio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-60-0075	17. INFORMANT'S OWN SIGNATURE + Catherine A. Bieler	ADDRESS 6620 Morton Dr. Boise	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1969

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic carcinoma of abdominal organs, primary site not identified

INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* any *, 19*58*, to* present - death *, 19*_____*, that I last saw the deceased alive on* Oct 16 *, 19*69*, and that death occurred at* 3:30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE O. R. Blackburn 046 (Degree or title) MD	23b. ADDRESS 800 La Cassia Boise Ida	23c. DATE SIGNED 20 Oct 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 20, 1969	24c. NAME OF CEMETERY OR CREMATORY Cloverdale	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Oct. 21, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Earl Waggoner	LICENSE NO. E-422

FIRM NAME: Alden-Waggoner

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 8 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4470
Local Reg. No. 774
Reg. Dist. No. 370

BIRTH NO.

OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 300 South Straughn	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho d. STREET ADDRESS (If rural, give location): 300 South Straughn

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Janet	Little	Falk	10	17th	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Jan. 21, 1917	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Same	Emmett, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Little	Scotland	Ellen ------	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		* Harris Falk	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

956X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Self Inflicted Injuries. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Razor Blade. Cut Veins in both Arms.
DUE TO (c) Despondence. — Mins;

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
2 Suicide		13 11

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See to Alive, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 10P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. D. Paris	Coroner	3720 Meadow Drive, Boise.	10-24-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-22-69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 27 1969	Myrtle Palmer	Orle B. Bryan	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 22 1969
Bureau of Vital Statistics

State File No. 4471
Local Reg. No. 667
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION: Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 506 E. Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): Susan
b. (Middle): Myrtle
c. (Last): Neibaur

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 24, 1887
9. AGE (In years last birthday): 82
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Granite Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William S. Thomson
BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Martha De Spain
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-07-1432 A
17. INFORMANT'S OWN SIGNATURE: Mrs C. L. Egbert
ADDRESS: Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 486X Pneumonia
INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes - Hypertension.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1968, to Oct, 1969, that I last saw the deceased alive on 18 Oct, 1969, and that death occurred at 9:15 A m., from the causes and on the date stated above.

23a. SIGNATURE: Mark H. Bell, MD (Degree or title): 039
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 10/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-21-69
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Oct. 22. 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Jack H. Green
LICENSE NO.: E-528
FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4472
Local Reg. No. 780
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Nellie b. (Middle) Armstrong c. (Last) Smit

4. DATE OF DEATH (Month) (Day) (Year) October 18, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH April 26, 1896

9. AGE (In years last birthday) 73
IF UNDER 1 YR. Months 5 Days 22
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY home

11. BIRTHPLACE (State or foreign country) Antonito, Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Edward Broyles
BIRTHPLACE Dalton, Georgia

14. MOTHER'S MAIDEN NAME Nellie Armstrong
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 523-24-1319

17. INFORMANT'S OWN SIGNATURE X Robert G. Shane
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac Arrythmia

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Car accident with
DUE TO (c) Cervical cord compression

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) 1

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 00

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Car accident

22. I hereby certify that I attended the deceased from Oct, 1969, to Oct 16, 1969, that I last saw the deceased alive on Oct 16, 1969 and that death occurred at 7:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ph. A. Hathaway M.D.

23b. ADDRESS 401 Idaho St., Boise, Ida.

23c. DATE SIGNED 10-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Oct. 20, 1969

24c. NAME OF CEMETERY OR CREMATORY Parkview

24d. LOCATION (City, town, or county) (State) New Plymouth, Idaho

DATE REC'D BY LOCAL REG. Oct. 28 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Thurman W. Beatty

LICENSE NO. E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 3 0 1969
FEB 2 5 1970
APR 2 0 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4473
Local Reg. No. 771
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 27 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Ada b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise d. STREET ADDRESS (If rural, give location): 7516 Warm Springs Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	(Mrs) Frank	H.	Zeh	Oct. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Oct. 10, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Anson, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Hustead	W. Virginia	Anna Shoemaker	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-07-0880	X Mrs. Margueritte Burton	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer of Colon — INTERVAL BETWEEN ONSET AND DEATH: 7 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March 11, 1969, to Oct 18, 1969, *that I last saw the deceased alive on* 10-16, 1969, *and that death occurred at* 9:47 AM, *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Maurice M. Rublweiler, M.D. (Degree or title)	848 La Cassia, Reno	10/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 21, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 24, 1969	Myrtle Palmer	Kenneth E. Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4474
Local Reg. No. 148
Reg. Dist. No. 371

BIRTH NO.

RECEIVED NOV 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 96 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN. HOSPITAL BOISE, IDA.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ELMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GLENNS FERRY
d. STREET ADDRESS (If rural, give location): 304 EAST CLEVELAND

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HAROLD	(NMI)	BYBEE	OCTOBER 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	DEC. 23, 1895	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railroad engineer	RAILROAD	MILO, IDAHO	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
R.L. BYBEE	UNKNOWN	HARRIET RAYMOND	UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWI 3	A712 05 3331	VA HOSPITAL RECORDS, BOISE, IDAHO	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 209X Myeloproliferative syndrome.

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Unknown.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from JULY 15, 1969, to OCTOBER 19, 1969, and that death occurred at 3:20 pm from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
FRED B. HINE, M.D.	VA CENTER, BOISE, IDAHO	10/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/24/69	Glenn Rest Cemetery	Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 13, 1969	Myrtle Palmer	Arthur Smith	E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4475
Local Reg. No. 772
Reg. Dist. No. 270

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada OCT 27 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Boise
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho City
d. STREET ADDRESS (If rural, give location) Idaho City Box 14

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Joseph	Webster	Jones	Oct.	19	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct 9, 1912	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equipment Operator
10b. KIND OF BUSINESS OR INDUSTRY same
11. BIRTHPLACE (State or foreign country) Hamill South Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph T. Jones — BIRTHPLACE South Dakota
14. MOTHER'S MAIDEN NAME Ellen Moran — BIRTHPLACE Wood South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 504-12-3154
17. INFORMANT'S OWN SIGNATURE Joseph W Jones Jr. ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 5770 Cholestatic Hepatitis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pancreatitis —
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Peptic ulcer Duodenum

19a. DATE OF OPERATION 9-5-'69
19b. MAJOR FINDINGS OF OPERATION Penetrating bleeding ulcer duodenum
20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-2, 1968, *to* 10-19, 1968, *that I last saw the deceased alive on* 10-29, 1969, *and that death occurred at* 2 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title) Evere N. Jones M.D. 268
23b. ADDRESS Boise
23c. DATE SIGNED 10-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	10-23-69	Idaho City Cemetery	Idaho City	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 24 1969	Myrtle Palmer	Ernest B. Byram	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 0 1969

NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 1 0 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 2 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

AUG 2 7 1979

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4476
Local Reg. No. 775
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 607 Grove

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Hermenegilda		Uberuaga	10-	19-	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	May 25, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	Same	Bolivar Viscaya Spain	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pedro Bernedo	Spain	Irionaguena	Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		X Jesus Uberuaga	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Diabetis mellitis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral hemorrhage — 1 day

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 1st 1969 *to* Oct 19 1969, *that I last saw the deceased alive on* Oct 19 1969, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
550 Roscoe B Ward MD	Boise Idaho	10/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-22-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 27 1969	Myrtle Palmer	Earl D. Byram	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 8 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4477
Local Reg. No. 668
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 24 1969
Bureau of Vi

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6700 Hill Rd.

3. NAME OF DECEASED (Type or Print): a. (First) Wilma b. (Middle) Amanda c. (Last) Whitmore

4. DATE OF DEATH (Month) (Day) (Year): 10/19/69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Feb. 4, 1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Credit Manager >6	Glass	Benton Harbor, Mich.	USA

13. FATHER'S NAME: [illegible] Denney — BIRTHPLACE: Not listed
14. MOTHER'S MAIDEN NAME: Mae (unk.) [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 375-16-2960
17. INFORMANT'S OWN SIGNATURE: Lucena J. Whitmore — ADDRESS: 6700 Hill Rd.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute pancreatitis & peritonitis	6 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Posterior penetrating marginal ulcer	8 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Cholelithiasis	1 yr

5341

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Oct 13, 1969	Cholelithiasis, Penetrating ulcer	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Boise (COUNTY) Ada (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible] 19 62 *, to* Oct 19 *, 19* 69 *, that I last saw the deceased alive on* Oct 19, 1969 *, 19* ____ *, and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Quentin E. Coward MD 347	401 Idaho St Boise	Oct 23, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation 2	10/23/69	Mountain View	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 24, 1969	Myrtle Palmer by [illegible]	[illegible]	E-527

FIRM NAME: Mountain View Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4478
Local Reg. No. 793
Reg. Dist. No. 370

Certificate of Death

RECEIVED
NOV 3 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 8 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 737 West 18th Street

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Albert
c. (Last): Dalton

4. DATE OF DEATH (Month) (Day) (Year): Oct. 20, 1969

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 14, 1937
9. AGE (In years last birthday): 32 — IF UNDER 1 YEAR: Months 7, Days 6 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Press Operator
10b. KIND OF BUSINESS OR INDUSTRY: Boise Cascade
11. BIRTHPLACE (State or foreign country): Hamilton, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Charles Albert Dalton, San Diego, Calif.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Ada Poindexter, Victor, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Korean
16. SOCIAL SECURITY NO.: 518-40-1630
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Geraldine Dalton, 737 W 18th Burley, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH: Ida

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1969 *to* Oct, 1969 *that I last saw the deceased alive on* 10 26, 1969, *and that death occurred at* 12:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Oct. 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Nov. 3, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer / JLD
25. EMBALMER: [signature]
LICENSE NO.: E-410

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 15 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4479
Local Reg. No. 662
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 21 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1703 North 13th.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEE	OLIVER	ROBERTS	Oct. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 11, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Farmer 094	Farmer	Elgin, Oregon	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Newton Roberts	Missouri	Orlena Sly	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.I		+ Mrs Lee O Roberts	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1719 Metastatic fibrosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept, 19 66 *to* Oct 20, 19 69, *that I last saw the deceased alive on* Oct 20, 19 69, *and that death occurred at* 1:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
054 Walter A. Klein	M.D.	425 W Bannock Boise	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-22-1969	Terrace Lawn	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 21 1969	Myrtle Palmer	Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

425 W. Bannock

OCT 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4480
Local Reg. No. 776
Reg. Dist. No. 370

BIRTH NO.

OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 21 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 503

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Melba
d. STREET ADDRESS (If rural, give location) ****

3. NAME OF DECEASED (Type or Print) a. (First) Clifford b. (Middle) (nmn) c. (Last) Robinson

4. DATE OF DEATH (Month) (Day) (Year) Oct. 20, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Feb. 27, 1886
9. AGE (In years last birthday) 83
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Well Driller 21
10b. KIND OF BUSINESS OR INDUSTRY Oil Fields
11. BIRTHPLACE (State or foreign country) Crawford Co., Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James M. Robinson BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME Susie P. Glines BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 517 03 9834
17. INFORMANT'S OWN SIGNATURE X H. D. Pfister ADDRESS Melba, Idaho

18. CAUSE OF DEATH 8199
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Head Injury

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Car accident

22. *I hereby certify that I attended the deceased from* Sept, 1961, *to* Oct, 1969, *that I last saw the deceased alive on* Oct 20, 1969 *and that death occurred at* 5:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE 704 [signature] (Degree or title)
23b. ADDRESS 401 Idaho, Boise, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-23-69
24c. NAME OF CEMETERY OR CREMATORY Melba Cemetery
24d. LOCATION (City, town, or county) (State) Melba, Idaho

DATE REC'D BY LOCAL REG. Oct. 27 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Glen Siren
LICENSE NO. 498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 30 1969

Bureau of Vital Statistics

State File No. 4481
Local Reg. No. 139
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY IN (this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: OREGON 38
b. COUNTY: MALHEUR 535
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ONTARIO
d. STREET ADDRESS (If rural, give location): 271 SOUTHEAST 6TH AVENUE

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEE	(NONE)	STREET	OCTOBER 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	NEVER MARRIED	APRIL 16, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER 04	FARMING	MADISON COUNTY, INDIANA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J.W. STREET	INDIANA	ROSIE JONES	INDIANA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWI	720 03 5331	Lewis Lentley	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Sarcoma, retroperitoneal — INTERVAL BETWEEN ONSET AND DEATH: 6 months +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Atrophy of right kidney — Unknown

1580

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from OCTOBER 20, 1969, to OCTOBER 20, 1969, and that death occurred at 11:15p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis, M.D. ROBERT C. LEWIS, M.D. 597	VA CENTER, BOISE, IDAHO	10/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-21-69		Ontario, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 28 1969	Myrtle Palmer	Harold D. Demaray	E-509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4482
Local Reg. No. 141
Reg. Dist. No. 371

BIRTH NO.

RECEIVED OCT 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE

c. LENGTH OF STAY (In this place) 1ST DAYS

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE

d. STREET ADDRESS (If rural, give location) 3606 MOORE STREET

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JEP	(NMI)	WHITEHEAD	OCTOBER 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	MAY 4, 1895	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	UNKNOWN	ARDMORE, OKLAHOMA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOHN WHITEHEAD	UNKNOWN	MATTIE BAILEY	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI	519 01 02 17	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic obstructive pulmonary emphysema. — INTERVAL BETWEEN ONSET AND DEATH: 25 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I attended the deceased from APRIL 22, 1969, to OCTOBER 20, 1969, and that death occurred at 4:15a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
FRED B. HINE, M.D. 547 [signature]	VA CENTER, BOISE, IDAHO	10/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/22/1969	Syringa Gardens Cem.	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30, 1969	Myrtle Palmer	A. E. Alden	E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38:206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1 1969

OCT 1 2 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

State File No. 4483
Local Reg. No. 777
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho 13 b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (If outside place)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 023	d. STREET ADDRESS (If rural, give location): 312 Chestnut St.

3. NAME OF DECEASED (Type or Print) a. (First): RICHARD	b. (Middle): G.	c. (Last): CARLSON	4. DATE OF DEATH (Month) (Day) (Year): October 21, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: January 23,1907	9. AGE (In years last birthday): 62 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. Carman 10	10b. KIND OF BUSINESS OR INDUSTRY: P.F.E. Shops	11. BIRTHPLACE (State or foreign country): La Grande, Oregon	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Charles Carlson	BIRTHPLACE: Idaho	14. MOTHER'S MAIDEN NAME: Eva A. Peterson	BIRTHPLACE: Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 711 05 2930	17. INFORMANT'S OWN SIGNATURE: X Imogene Carlson	ADDRESS: Nampa, Ida.	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): cerebro-vascular accident

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): arteriosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 10/20/69	19b. MAJOR FINDINGS OF OPERATION: normal cerebral angiogram	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-18-69 m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR? minimal head injury

22. *I hereby certify that I attended the deceased from* 10/19, 1969, *to* 10/21, 1969 *that I last saw the deceased alive on* 10/21, 1969, *and that death occurred at* 10:05P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Edward Stefer (Degree or title): M.D.	23b. ADDRESS: 616 Eastman Bldg. Boise	23c. DATE SIGNED: 10/23/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10/24/1969	24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery	24d. LOCATION (City, town, or county) (State): Canyon County Idaho
DATE REC'D BY LOCAL REG.: Oct. 27 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: [signature]	LICENSE NO.: F496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969
NOV 4 1969
NOV 1 0 1969
DEC 8 1969
DEC 1 - 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 4484
Local Reg. No. 798
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 5 1969 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada 011

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 2307 N. 31st St.

3. NAME OF DECEASED (Type or Print)

a. (First): Annie

b. (Middle): Mary

c. (Last): Yearian

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 20, 1876

9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Junction City, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Gray L. Purcell — BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: Drucella Winters — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-58-9665

17. INFORMANT'S OWN SIGNATURE: X Anna Mae Atherton — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1949 *to* Oct 21, 1969 *that I last saw the deceased alive on* 10-13, 1969, *and that death occurred at* 5:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice M. Rubinstein, MD 071

23b. ADDRESS: 848 La Cassia, Boise

23c. DATE SIGNED: 10/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/24/1969

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Nov. 3, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Emil Waggoner — LICENSE NO. E-422

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alden-Waggoner Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4485
Local Reg. No. 789
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 30 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 16 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 420 Sierra Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GARRETT	CARSON	ALVIS	Oct. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Aug. 7, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bonded Police, Inc.	Bonded Police	Eidson, Tennessee	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Thomas Alvis	Tenn.	Mattie Anderson	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	413-10-0939	+ Bill R. Alvis	Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Pulmonary Emphysema, Leukemia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/2, 1964, *to* 10-22, 1969, *that I last saw the deceased alive on* 10-21, 1969, *and that death occurred at* 5:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. Thomas Merrill MD	Boise Ida	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-25-1969	Cloverdale Cemetery	Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30, 1969	Myrtle Palmer	Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

OCT 30 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4486
Local Reg. No. 138
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian rural
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian rural
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Daniel	L.	Barker, Jr.	Oct. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 20, 1924	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Federal Meat Inspector		Canada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel L. Barker	Nebraska	Doris Jolly	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW 2	518-32-2807	Mrs Dan Barker	Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* 11:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 E. O. Paris	Coroner	3720 Meadow Drive, Boise.	10-27-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-25-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 28 1969	Myrtle Palmer	Jack K. Green	E-528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 8 1969

NOV 1 2 1969

FEB 2 6 1970

MAY 4 1970

MAY 1 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4487
Local Reg. No. 773
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 27 1969 Vital Statistics Bureau of

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idah
c. LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls Idaho
d. STREET ADDRESS (If rural, give location): 259 Pierce

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Nelle	M.	Bickford	10	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	7-15-1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Same	Curtis Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John McKnight	Curtis Nebraska	Jane McKnight	Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-07-8300-D	Helen F. Redington	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ca Thymus Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1533

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/10/69		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 19 54, *to* October 22, 19 69, *that I last saw the deceased alive on* October 22, 19 69, *and that death occurred at* 8:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard A. Forney, M.D.	425 W. Bannock Boise, Ida.	10/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-25-69	Sunset Memeral Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 24 1969	Myrtle Palmer	Daniel G. Gibson Gibson Funeral Home	400

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 17 1969
MAR 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4488
Local Reg. No. 1297
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada — OCT 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Highway 30 and Black Creek
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Highway 30 and Black Creek

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 1711 Resseguie

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Daniel	Eugene	Elguezabal	10	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	June 29, 1942	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Designer Boise Floral		Gooding, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred Elguezabal	Spain	Juana Ascuena	Gooding, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Fred Elguezabal	Boise

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiply Head Injuries. — Interval between onset and death: Brief

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: Broken Neck

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	06		13010	

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED AT WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
10	22	69	1205 m.		Auto Tire Blow out. Traveled 670 Ft; Flipped over in Barrow Pit.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 1205A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise	10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-25-69	Gooding, Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 27 1969	Myrtle Palmer	Earl B Byram	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

OCT 2 8 1969

OCT 2 9 1969

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4489
Local Reg. No. 811
Reg. Dist. No. 270

BIRTH NO.

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4678 Chinden Blvd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Fredrick	Jay	Marsh	Oct. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Sept. 3, 1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Laborer	Janitorial	Rexburg, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Grant Marsh	Kansas	Myrtle Harper	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
NO	518-16-0575	Fredrick Jay Marsh Jr.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 5710 Pancreas Carcinoma

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic alcoholism
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/16, 1969, *to* 10/22, 1969, *that I last saw the deceased alive on* 10/22, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jay Borup M.D	Boise Idaho	11/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/27/1969	Star Cemetery	Star, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 7 1969	Myrtle Palmer	Gould Waggoner	E-422

FIRM NAME: Arden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 14 1969
OCT 25 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 30 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4490
Local Reg. No. 781
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Apt. 2, Mesa Vista Dr.

3. NAME OF DECEASED (Type or Print): a. (First) LUCILE b. (Middle) LANT c. (Last) OBERHANSLEY

4. DATE OF DEATH (Month) (Day) (Year): Oct 22, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: May 8, 1898
9. AGE (In years last birthday): 71
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Utah
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 62 5884M
17. INFORMANT'S OWN SIGNATURE: x Carol O. Smith ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis
With Obstruction & myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Arterio-sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-28, 19 50, *to* 10-22, 19 69, *that I last saw the deceased alive on* 10-22, 19 69, *and that death occurred at* 5:45 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): 528
23b. ADDRESS: 305 Fort St. Boise, Idaho
23c. DATE SIGNED: 10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal to
24b. DATE: 10-25-69
24c. NAME OF CEMETERY OR CREMATORY: Ogden City Cemetery
24d. LOCATION (City, town, or county) (State): Ogden, Utah

DATE REC'D BY LOCAL REG.: Oct. 28, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Hunt
LICENSE NO.: E478
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 6 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4491
Local Reg. No. 796
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): Route # 2, So. of City

3. NAME OF DECEASED (Type or Print)
a. (First): Esther
b. (Middle): Myrtle
c. (Last): SMITH

4. DATE OF DEATH (Month) (Day) (Year): October 22, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: April 10, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months – Days – IF UNDER 24 HRS.: Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: Education
11. BIRTHPLACE (State or foreign country): Cedar Rapids, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Amos H. Smith — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Elizabeth Searby — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): – –
16. SOCIAL SECURITY NO.: 519-42-1416 A
17. INFORMANT'S OWN SIGNATURE: Charles E Babbitt — ADDRESS: 6242 Arlington Dr Boise Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4442

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Mesenteric thrombosis — 1 week
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 3:15P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert H Morrell 37, MD
23b. ADDRESS
23c. DATE SIGNED: 10/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-17-1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Cemetery
24d. LOCATION (City, town, or county) (State): Cedar Rapids, Boone Cy, Nebraska

DATE REC'D BY LOCAL REG.: Oct. 31, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Keith M. Jensen — LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4492
Local Reg. No. 782
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada — OCT 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION: Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route #2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HARRY	LEE	YOST	Oct.	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Feb. 16, 1880	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Postmaster	Post Office	Houcktown, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Yost	Ohio	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-36-0913	Box 308	Emmett, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis
Adult Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1969, *to* Oct, 1969, *that I last saw the deceased alive on* Oct. 1, 1969, *and that death occurred at* 8 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. C. Johnson MD	Boise Ida	10-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 24, 1969	Cloverdale	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 28 1969	Myrtle Palmer	Robert L. Summers	E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM PH-63021

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4493
Local Reg. No. 783
Reg. Dist. No. 370

RECEIVED OCT 30 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 121 E. King

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 121 E. King

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Marion	T.	Gillaspy	Oct. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 4, 1910	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Laborer		Manchester, Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Gillaspy	Unk.	Ethiel E White	Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-12-2404	Calvin L Gillaspy	Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4927

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Emphysema — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, that I last saw the deceased alive on ____, 19____ and that death occurred at 2:00A m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. Paris, MD	Coroner	3720 Meadow Drive, Boise.	10-27-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-31-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 28 1969	Myrtle Palmer	Jack K Green	E-528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4494
Local Reg. No. 786
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Ada OCT 31 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise LENGTH OF STAY (In this place): 2 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2504 Grandee	d. STREET ADDRESS (If rural, give location): 2504 Grandee

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EPHA	T.	SUTCLIFFE	Oct. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Oct. 31, 1886	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	home	Palo Pinto, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ephriam K. Taylor	Kentucky	Samantha Jane Hutchison	Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	None	Philip J. Sutcliffe	3490 Pocatello Road, Pocatello, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	4369 Cerebral Vascular Accident	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 1969 *to* Sept, 1969, *that I last saw the deceased alive on* Sept 11, 1969, *and that death occurred at* 11:20 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bruce Moody MD	2429 N. Cole Rd	10/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	10-27-69	Mtn View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 29 1969	Myrtle Palmer	Gary A. Carver	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 31 1969

NOV 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4495
Local Reg. No. 787
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 31 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3505 Sycamore Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	Reese	Thompson	Oct. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 9, 1932	37		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Office Machines	Tulsa, Oklahoma	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clayton Hatley	Missouri	Waunita Lynch	Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
Yes 1/9/47 5/20/48	448-26-3528	Raymond J Thompson 3505 Sycamore Dr. Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4369 S Cerebral vascular accident 2/2 Cerebral deterioration — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Small bowel obstruction partial 2 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-16- , 19 69 , *to* Oct-23 , 19 69 , *that I last saw the deceased alive on* Oct-23, 19 69 , *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glenn E Galin M.D.	125 E Idaho	10/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-27-69	Syringa Gardens Cemetery, Boise, Idaho	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30 1969	Myrtle Palmer	J. U. Magee	E 390

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

OCT 31 1969

JUN 17 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 26 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4496
Local Reg. No. 778
Reg. Dist. No. 570

BIRTH NO.

RECEIVED OCT 28 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION: 7403 Colehaven Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Oregon
b. COUNTY: Wallowa
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Joseph
d. STREET ADDRESS (If rural, give location): Box 10

3. NAME OF DECEASED (Type or Print): a. (First) Richard b. (Middle) L. c. (Last) Blankinship

4. DATE OF DEATH: (Month) 10 (Day) 24 (Year) 69

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 7-6-15

9. AGE (In years last birthday): 54
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher & Meat Cutter
10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Peola, Washington

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel E. Blankinship
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Delia
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WWII
(If yes, give war or dates of service): Yes

16. SOCIAL SECURITY NO.: 519-12-4573

17. INFORMANT'S OWN SIGNATURE: X Marian J. Blankenship
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: instantaneous

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): with myocardial infarction
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Previous atherosclerosis of coronary vessels — Apr 69

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from not seen, 19 before death, 19, that I last saw the deceased alive on , 19, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE: O.R. Blankenship M.D. (Degree or title)
23b. ADDRESS: 800 La Cresta Boise Idaho
23c. DATE SIGNED: 27 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-28-69
24c. NAME OF CEMETERY OR CREMATORY: Praire Creek Cemetery
24d. LOCATION (City, town, or county) (State): Joseph, Oregon

DATE REC'D BY LOCAL REG.: Oct. 27 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Clyde J. Vassar
LICENSE NO.: E-535
FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 0 1969
NOV 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4497
Local Reg. No. 788
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 30 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Ada 01	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho 13 b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 10 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital 01 3	d. STREET ADDRESS (If rural, give location): 2021 Cribbens St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ambrose	M.	McCarthy	10	24	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct 21, 1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Mang: of Deg and Platter 26	Same	Heartwell, Neb	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Minnon, Neb.	Emma Billosbach	Heartwell, Neb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWII 4	518-18-4959	Mrs Ambrose M. McCarthy	

5719

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute hepatic failure	2 weeks.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Gastro-intestinal bleeding.	2 weeks.
DUE TO (c)	Cirrhosis of the liver	Unknown.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	None	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-19-69	Cirrhosis	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct. 15, 19 69, *to* Oct. 24, 19 69, *that I last saw the deceased alive on* Oct. 24, 19 69 *and that death occurred at* 1:38p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Quentin E. Howard MD	10-28-69	401 Idaho St. Boise, Idaho	10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-27-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30 1969	Myrtle Palmer	Eddie P. Bryan	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

OCT 30 1969
NOV 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 9 - 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 31 1969 Bureau of Vital Statistics

State File No. 4498
Local Reg. No. 143
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. # 3 S. Cole Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) Rt. # 3 S. Cole Rd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
KEVIN	K.	MORRIS	Oct. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	June 23, 1961	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 03		Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Karl Morris	Okla.	Eileen Kumasawa	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	X Karl Morris	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 9139 Suffication. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Trapped in Closed, Abandoned, Side Door of Old Washing Machine. standing out behind a Shed.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	28	13010

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *to* _____, 19____, *that I last saw the deceased alive on* _____, *and that death occurred at* 6P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. O. Paris 383	Coroner	3720 Meadow Drive, Boise	10-30-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	10-29-69	Cloverdale Memorial Park	Boise,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30, 1969	Myrtle Palmer	Clyde J. Vassar	E-535

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 1969
OCT 13 1998

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4499
Local Reg. No. 799
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place):
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 2409 Iowa

3. NAME OF DECEASED (Type or Print) a. (First): Elaine	b. (Middle): M.	c. (Last): Peterson	4. DATE OF DEATH (Month) (Day) (Year): Oct. 24, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: May 2, 1894	9. AGE (In years last birthday): 75 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Trenton, Texas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: M A Peterson	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1941

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Rt. Cerebral infarction

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis + Parathyroid adenoma
DUE TO (c): Para thyroid adenoma

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 10/28/69	19b. MAJOR FINDINGS OF OPERATION: Para thyroid adenoma	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/9/ *, 19*69*, to* 10/23/ *, 19*69*, that I last saw the deceased alive on* 10/23/ *, 19*69*, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Edward Grifer (Degree or title) M.D.	23b. ADDRESS: 616 Eastman Bldg	23c. DATE SIGNED: 10/27/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct. 28, 1969	24c. NAME OF CEMETERY OR CREMATORY: Wilder Cemetery	24d. LOCATION (City, town, or county) (State): Wilder, Idaho
DATE REC'D BY LOCAL REG.: Nov. 3, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: James R. Dakan	LICENSE NO.: E-485

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 0 1969

NOV 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4500
Local Reg. No. 792
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Ada 01

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

DURATION OF STAY (in this place):

c. HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada 01

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 505 Bitterroot Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Charlotte	Christine	Tarleton	Oct. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Sept. 24, 1938	31				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Wapello, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wayne Wadsworth	Taylor, Idaho	Viola Hansen	Shelley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO			x Donald L Tarleton	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

6954

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Lupus erythematosis — INTERVAL BETWEEN ONSET AND DEATH: 18 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 30 Nov, 1963, *to* 24 Oct, 1969, *that I last saw the deceased alive on* 24 Oct., 1969, *and that death occurred at* 5:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	6003 Overland Boise, Ida	29 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/28/1969	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Myrtle Palmer	Hoard Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 7 1992

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 2 1993

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 4501
Local Reg. No. 142
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA OCT 31 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
LENGTH OF STAY (In this place) 138 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDAHO 804

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 1721 DIVISION AVENUE

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LILLIAN	LOUISE	ARNOLD	OCTOBER 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	MARRIED	DECEMBER 6, 1916	52	--- / ---	--- / ---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	SAME	NEW YORK CITY, NEW YORK	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
OLAF HUSELEY	NORWAY	AGNES OISEN	NORWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII	087-07-0963	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

174X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cachexia	10 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Carcinoma of the right breast with extensive metastases to lungs, retinas and skeleton	3 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-19-67	Infiltrative adenocarcinoma of right breast without lymph node involvement.	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from JUNE 9, 19 69, to OCTOBER 25, 19 69, and that death occurred at 2:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J.K. HELBERTY, M.D. [signature] M.D.	VA CENTER, BOISE, IDAHO	10-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-28-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30 1969	Myrtle Palmer	J. U. Magee	E. 340

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 31 1969
MAR 8 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Blank permit
1 copy

Certificate of Death

STATE OF IDAHO

State File No. 4502
Local Reg. No. 805
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) Rt. #2, N. Maple Grove Road

3. NAME OF DECEASED (Type or Print) a. (First) Gladys b. (Middle) Jepson c. (Last) Shanholtz Hawley

4. DATE OF DEATH (Month) Oct. (Day) 25, (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 19, 1897

9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY ---

11. BIRTHPLACE (State or foreign country) Oakley, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alonzo Broyles — BIRTHPLACE Munsie, Ind.

14. MOTHER'S MAIDEN NAME Mettie Laurance — BIRTHPLACE Viroque, Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-24-6527A

17. INFORMANT'S OWN SIGNATURE X Bernice A. Brown — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2871

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute intra bronchial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few mins.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Idiopathic Thrombocytopenic purpura — 4 mo

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 Dec, 1962 *to* 25 Oct, 1969, *that I last saw the deceased alive on* 25 Oct, 1969, *and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE J. Hug L. Attilly 014 (Degree or title) MD

23b. ADDRESS 401 Idaho St Boise Idaho

23c. DATE SIGNED 3 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE 10-29-69

24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. Nov. 6, 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Earl Waggoner

LICENSE NO. E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 27 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 5 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4503
Local Reg. No. 800
Reg. Dist. No. 370

1. PLACE OF DEATH — County: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 21 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 711 North 20th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARTHA	E.	OLSEN	Oct. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Aug. 21, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Administrator 08	State of Idaho	Longton, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Blevins	Missouri	Lucinda Gardner	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-28-6725	Edward O. Olsen	711 N. 20th Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Thrombosis	Brief
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral arteriosclerosis	10-15 yrs.
DUE TO (c)	Generalized arteriosclerosis	10-15 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Recent respiratory infection	Few days.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9-21, 1964, to 10-25, 1969, that I last saw the deceased alive on 10, 1969, and that death occurred at 7:00 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. L. Newcombe, M.D.	512 N. 16 St. Boise, Idaho, 83702	10-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-28-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Myrtle Palmer	[illegible]	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Was Called Called Tested
Crab Lake accident Between 1962 and 10:15 69

Certificate of Death

STATE OF IDAHO

State File No. 4504
Local Reg. No. 140
Reg. Dist. No. 371

BIRTH NO.

RECEIVED Bureau of Vital Statistics OCT 31 1969

1. PLACE OF DEATH
a. COUNTY ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 3 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE OREGON 38
b. COUNTY MALHEUR 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ONTARIO
d. STREET ADDRESS (If rural, give location) 698 SOUTH EAST SECOND STREET

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLAIR	J	PEARSON	OCTOBER 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	JUNE 14, 1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LOCOMOTIVE OPERATOR	RAILROAD	MITCHELL, OREGON	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
MONTY PEARSON	TENNESSEE	BERTIE HOLEMAN	WASHINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII +	541-30-8745	James Pearson	VA HOSPITAL RECORDS, BOISE, IDAHO

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute myocardial infarction	4-6 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	15 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I, VA, attended the deceased from OCTOBER 22, 19 69 to OCTOBER 25, 19 69, and that death occurred at 3:45 a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis, M.D. 597 ROBERT C. LEWIS, M.D. 597	VA CENTER, BOISE, IDAHO	10-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-25-69		Ontario, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 29 1969	Myrtle Palmer	Dale McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1 1969

DEC 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 9 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

FEB 1 3 1975

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4505
Local Reg. No. 832
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 19 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 Hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4780 Goodall Street

3. NAME OF DECEASED (Type or Print)
a. (First): BARBARA
b. (Middle): ANNE
c. (Last): VOGT

4. DATE OF DEATH (Month) (Day) (Year): Oct. 25, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Nov. 2, 1953
9. AGE (In years last birthday): 15
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Vogt, BIRTHPLACE: Dennison Iowa
14. MOTHER'S MAIDEN NAME: Dorothy Brogdon, BIRTHPLACE: Leesville, La.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Henry L Vogt, ADDRESS: 4780 Goodall Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Head Injury

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Trauma
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Street
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Boise 13011
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-25-69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Apparently by a car

22. I hereby certify that I attended the deceased from 10-25, 1969 to 10-25, 1969, that I last saw the deceased alive on 10-25, 1969, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE: 704 A H Lingendall (Degree or title)
23b. ADDRESS: 401 Idaho Street
23c. DATE SIGNED: 11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-29-69
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Nov. 19 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Howell D Demaray
LICENSE NO.: E-509

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4506
Local Reg. No. 790
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 31 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Ada

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (In this place): 10 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Ada

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 3012 Grace

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ESTHER	ALICE	WHARTON	Oct. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Nov. 17, 1914	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James William Matlick	Missouri	Alice Louise Heard	Baker, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.		E. Clair Wharton	Boise, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized coronary arteriosclerosis — Several yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Perforated duodenal ulcer.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-15-69	Poerforated duodenal ulcer.	Yes XX No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-15-69, 19__, to 10-25-69, 19__, *that I last saw the deceased alive on* 10-25-69, 19__, *and that death occurred at* 5:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Quentin C. Howard MD 247	401 Idaho St. Boise, Idaho	10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-29-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 31, 1969	Myrtle Palmer, ILD	Elton T. Pearson	E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

6961 I E 130
MAR 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
NOV 5 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4507
Local Reg. No. 791
Reg. Dist. No. 370
BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 4½ Months

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1932 Sunrise Rim

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

3. NAME OF DECEASED (Type or Print): a. (First) JUANITA b. (Middle) HANCOCK c. (Last) GRIFFITH
4. DATE OF DEATH (Month) (Day) (Year): Oct. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	April 7, 1910	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pharmacist 31	Lemp's Apothecary	Tucumcari, N. M.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel D. Bonar	Kentucky	Amazette Bennett	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-05-8372	R.C. Griffith	1932 Sunrise Rim Boise, Idaho

1579

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Carcinomatosis	10 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Adenocarcinoma of the pancreas	18 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 26 April, 1968, to 26 October, 1969, that I last saw the deceased alive on 25 October, 1969, and that death occurred at 6:00 AM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
524 Lyle Stones, M.D.	220 N. 1st St., Boise, Idaho	10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	10-29-69	Buhl Cemetery	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 31, 1969	Myrtle Palmer	Dale McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 7 1970

DEC 7 1970
MAR 13 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4508
Local Reg. No. 7248
Reg. Dist. No. 371

RECEIVED NOV 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Vetrans Home 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Newdale
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLAUDE	EDWARD	LARSON	25 Oct 69 26th

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Caucasian	Widower	12 April 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer CY	Own Farm- Retired	Winnipeg, Canada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oscar Larson	Lapland	Hilda ~~Lapland~~	Lapladd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	519-42-8370	M L Hansen	St. Anthony, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 493X Emphysema. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Medical Treatments for this. — Months.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did Not to See *to* Alive, 19__, *that I last saw the deceased alive on* 19__, *and that death occurred at* 330A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 5834	Coroner	3720 Meadow Drive, Boise.	11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	29 Oct 69	Teton-Newdale Cemetery	Sugar City, RFD, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 3 1969	Myrtle Palmer	M. D. Hansen	E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4509
Local Reg. No. 813
Reg. Dist. No. 370

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 2 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Rural Route 3 - Box 43

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Herman	Carl	Werle	Oct. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Nov. 22, 1902	66	11	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farming 04	farm	Emmett, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Werle	Germany	Johanna Wilhelm	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-22-7580	A. F. Werle	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4310

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral hemorrhage	17 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral arteriosclerosis	(?)yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hypertension Coronary heart disease	(?)yrs (?)yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-22- 1969 *to* 10-26 1969 *that I last saw the deceased alive on* 10-26 1969, *and that death occurred at* 6:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul F. Miner 364 MD	1333 W. Jefferson St Boise, Idaho	11/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3	Oct. 30, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Myrtle Palmer	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 2 1969

JUL 3 0 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4510
Local Reg. No. 794
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
NOV 3 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY IN THIS PLACE (If nonresident): 45 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 S. Jefferson St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1317 S. Jefferson

3. NAME OF DECEASED (Type or Print): a. (First) Herbert; b. (Middle) L; c. (Last) Fox

4. DATE OF DEATH (Month) (Day) (Year): Oct. 27, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 18, 1882

9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Claims Adjustor

10b. KIND OF BUSINESS OR INDUSTRY: UP Railroad

11. BIRTHPLACE (State or foreign country): Alba, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Fox
BIRTHPLACE: Unk.

14. MOTHER'S MAIDEN NAME: Artise Tipton
BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-09-4068

17. INFORMANT'S OWN SIGNATURE: Mrs Jessie Fox
ADDRESS: 1317 S. Jefferson, Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 4123 Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: (7 yrs)

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Cerebral arteriosclerosis — (??) yrs
Diabetes — 15 mos

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-26, 1968, *to* Oct 27, 1969, *that I last saw the deceased alive on* 10-6 ~~27~~, 1969, *and that death occurred at* 9:30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul F. Miner 364 MD

23b. ADDRESS: 1333 W. Jefferson Boise, Idaho

23c. DATE SIGNED: 11/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Entombment

24b. DATE: Oct. 30, '69

24c. NAME OF CEMETERY OR CREMATORY: Mountain View Mausoleum

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Nov 3, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Andrew P. Blanchard

LICENSE NO.: E-527

FIRM NAME: Mountain View Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 3 1968

DEC 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

BIRTH NO. OCT 3 1 1969

Certificate of Death
STATE OF IDAHO

State File No. 4511
Local Reg. No. 791
Reg. Dist. No. 370

Bureau of Vital Statistics

1. PLACE OF DEATH: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place) 8 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location) 3409 Kelly Way

3. NAME OF DECEASED (Type or Print)	a. (First) CHARLOTTE	b. (Middle) NOLAN	c. (Last) VAN WAGNER	4. DATE OF DEATH (Month) (Day) (Year) Oct. 28, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 24, 1891	9. AGE (In years last birthday) 78; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Ret) Federal 10	10b. KIND OF BUSINESS OR INDUSTRY Treasury Dept.	11. BIRTHPLACE (State or foreign country) New York City, N. Y.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Nolan	BIRTHPLACE Ireland	14. MOTHER'S MAIDEN NAME Agnes McCarney	BIRTHPLACE Scotland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO. 161-18-2034	17. INFORMANT'S OWN SIGNATURE Agnes E. Cloninger	ADDRESS 3409 Kelly Way Boise, Idaho	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Myocardial Infarction	4 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute Coronary Thrombosis	4hs
DUE TO (c)	Arteriosclerotic Heart Disease	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pneumonitis	

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 29, 1966, *to* October 28, 1969, *that I last saw the deceased alive on* October 28, 1969, *and that death occurred at* 11:05 AM *from the causes and on the date stated above.*

23a. SIGNATURE J. L. Quickstad, M.D. 426 (Degree or title)	23b. ADDRESS 6613 Ustick Road Boise, Idaho	23c. DATE SIGNED 10/29/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-30-69	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Oct. 31, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER [signature]	LICENSE NO. E-410

FIRM NAME SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 31 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4512
Local Reg. No. 813
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print): a. (First) Helen; b. (Middle) Thomas; c. (Last) Cannon

4. DATE OF DEATH (Month) (Day) (Year): October 29, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 25, 1912

9. AGE (In years last birthday): 57
IF UNDER 1 YR. Months: 3 Days: 4
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Bingham Canyon, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John E. Thomas
BIRTHPLACE: Schofield, Utah

14. MOTHER'S MAIDEN NAME: Persis Brown
BIRTHPLACE: Union, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 01 8879

17. INFORMANT'S OWN SIGNATURE: X James L. Cannon
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severe Bacteremic Shock — INTERVAL BETWEEN ONSET AND DEATH: 4-6 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Peritonitis — 24 hrs
DUE TO (c) Perforated duodenal ulcer — 24 hrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [✓] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/29/69, 19__, to 10/29/69, 19__, that I last saw the deceased alive on 10/29/69, 19__, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

23a. SIGNATURE: Leon W. Nowinski 393 (Degree or title)

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Nov. 3, 1969

24c. NAME OF CEMETERY OR CREMATORY: Parkview

24d. LOCATION (City, town, or county) (State): New Plymouth, Idaho

DATE REC'D BY LOCAL REG.: Nov. 10, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Glenn W Beatty

LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DR-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

MAY 18 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 16 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4513
Local Reg. No. 802
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST LUKE'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 419 So. 11th

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) W. c. (Last) COTTON

4. DATE OF DEATH (Month) (Day) (Year): Oct. 29, 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 5, 1876

9. AGE (In years last birthday): 93
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): TEXAS

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME / BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME / BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 01 9847A

17. INFORMANT'S OWN SIGNATURE / ADDRESS: John W. Cotton

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive heart failure

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Asthma & bronchitis.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/29, 1960, *to* 10/29, 1969, *that I last saw the deceased alive on* 10/29, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] M.D.

23b. ADDRESS: Boise Idaho.

23c. DATE SIGNED: 10/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov 1 1969

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Nov. 4, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4514
Local Reg. No. 809
Reg. Dist. No. 370

RECEIVED NOV 10 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY ADA 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place) 3 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes 002	d. STREET ADDRESS (If rural, give location) 2005 N 15th

3. NAME OF DECEASED (Type or Print) a. (First) Abbie	b. (Middle) Telitha	c. (Last) Hagler	4. DATE OF DEATH (Month) October (Day) 29 (Year) 1969	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 5 1880	9. AGE (In years last birthday) 88; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Stafford	BIRTHPLACE Illinois	14. MOTHER'S MAIDEN NAME Katty Eger	BIRTHPLACE unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE John N. Cressy	ADDRESS

885X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH 15-20 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fracture Hip.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10/19/69	19b. MAJOR FINDINGS OF OPERATION Fracture Rt femur	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Fell	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 01	21c. (CITY, TOWN, OR TOWNSHIP) Boise 13011 (COUNTY) Ada (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10/18/69 m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? Fell at home on box.

22. *I hereby certify that I attended the deceased from* 10/18/69, 19___, *to* 10/29/69, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 523 Kurt A Taylor (Degree or title)	23b. ADDRESS 119 E Idaho	23c. DATE SIGNED 11/6/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial; 24b. DATE Oct. 31, 1969	24c. NAME OF CEMETERY OR CREMATORY Morris Hill	24d. LOCATION (City, town, or county) Boise (State) Idaho
DATE REC'D BY LOCAL REG. Nov. 5 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Erle Byram E533 Erle B. Byram; LICENSE NO. E533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 14 1980

SEP 27 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 12 1990

NOV 25 2015

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4515
Local Reg. No. 8035
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada (11)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital (002)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1602 N. 22nd St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Edna	Orene	Anderson	Oct. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Jan. 3, 1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Home	Gooding, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Nester	Kansas	Annie Phillips	Soldier, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-28-9583	Melo G. Anderson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 174X Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH 13 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-30-69, 19__, *to* 10-30, 19 69, *that I last saw the deceased alive on* 10-30, 1969, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W M D Torrey 173	MD	425 Bannock Boise	10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-1-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 5 1969	Myrtle Palmer	Aldon Waggoner	E-422

FIRM NAME: Aldon Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

(1)

NOV 5 1969

NOV 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4516
Local Reg. No. 823
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise — c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hosp. 003	d. STREET ADDRESS (If rural, give location) 1722 Allumbaugh

3. NAME OF DECEASED (Type or Print)	a. (First) ELMA	b. (Middle) RAE	c. (Last) ELLEDGE	4. DATE OF DEATH (Month) 10/ (Day) 30 (Year) 1969		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Feb. 18, 1905	9. AGE (In years last birthday) 64	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing 21	10b. KIND OF BUSINESS OR INDUSTRY Letter Shop	11. BIRTHPLACE (State or foreign country) Milam County, Texas	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Lawrence	BIRTHPLACE Milan County Texas	14. MOTHER'S MAIDEN NAME Rosa Adele Small,	BIRTHPLACE Selma, Alabama			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 448-18-1666	17. INFORMANT'S OWN SIGNATURE X Mrs Virginia Goodrich	ADDRESS			

4310

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Intracerebral hemorrhage

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE R. L. Omeron 813 (Degree or title) M.D.	23b. ADDRESS Boise, Idaho	23c. DATE SIGNED 11/6/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 3, 1969	24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn	24d. LOCATION (City, town, or county) Boise (State) Idaho
DATE REC'D BY LOCAL REG. Nov. 14, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Eldon T. Pearson	LICENSE NO. E-512

Federal Security Agency
United States Public Health Service FORM OH-63021

FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics NOV 5 1969

State File No. 4517
Local Reg. No. 146
Reg. Dist. No. 371
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 85 days 260

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: BLAINE 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BELLEVUE

d. FULL NAME OF HOSPITAL OR INSTITUTION: VA HOSPITAL, BOISE, IDAHO 004
d. STREET ADDRESS (If rural, give location): Rt. 1, Box 570

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JACK	(nmi)	SOUTHERN	October 30 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	NOT MARRIED	8/7/07	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED SHEEPHERDER 07	SAME	GANNETT, IDAHO	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOHN SOUTHERN	YORKSHIRE, ENGLAND	ALICE J. RODGERS	UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII 4	519 16 3116	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

2050

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: terminal

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myelogenous leukemia, acute — 3 months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from 8/6, 1969, to 10/30, 1969, and that death occurred at 6:10a m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
M. G. Stromberg 597 (Degree or title) M. G. STROMBERG, M. D.	VA CENTER, BOISE, IDAHO	10/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-30-61		Hailey, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Myrtle Palmer	Robert G. Ross	E-477

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 3 1969
Bureau of Vital Statistics

State File No. 4518
Local Reg. No. 795
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 1 yr.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6620 Randolph Rd. 011	d. STREET ADDRESS (If rural, give location): 6620 Randolph Dr.

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Alton	c. (Last) Barsness	4. DATE OF DEATH (Month) (Day) (Year)	Oct. 31, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 3/12/25	9. AGE (In years last birthday): 44	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Professon of English 12	10b. KIND OF BUSINESS OR INDUSTRY: Boise State	11. BIRTHPLACE (State or foreign country): Lewistown, Montana	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Lawrence Barsness, BIRTHPLACE: Wisconsin		14. MOTHER'S MAIDEN NAME: Elizabeth Frances, BIRTHPLACE: Wisconsin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 576-26-6809	17. INFORMANT'S OWN SIGNATURE: Kyella D. Barsness, ADDRESS: 6620 Randolph Dr.			

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Diabetes Mellitus
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1968, *to* 10/31, 1969, *that I last saw the deceased alive on* _____, 19__ *and that death occurred at* 3:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: 654 [signature] (Degree or title) MD	23b. ADDRESS: 425 W. Bannock	23c. DATE SIGNED: 11/3/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2	24b. DATE: 11/3/69	24c. NAME OF CEMETERY OR CREMATORY: Mountain View	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Nov. 3, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: [signature]	LICENSE NO.: E-527

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Mountain View Funeral Home, Boise

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

6 -

NOV 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4519
Local Reg. No. 804
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1107 W. Washington Street 000	d. STREET ADDRESS (If rural, give location) 1107 W. Washington Street

3. NAME OF DECEASED (Type or Print)	a. (First) Frank	b. (Middle) L.	c. (Last) Bramblee	4. DATE OF DEATH (Month) (Day) (Year) 10-31-69
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11-22-1890	9. AGE (In years last birthday) 78 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 11	10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Council, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Miles Bramblee	BIRTHPLACE Virginia	14. MOTHER'S MAIDEN NAME Emily Moser	BIRTHPLACE Kentucky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I 3	16. SOCIAL SECURITY NO. 518-12-8545	17. INFORMANT'S OWN SIGNATURE X Mabel Bramblee	ADDRESS	

4369

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) History of Chronic Brain Syndrome

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis and Diabetes Mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I attended the deceased~~ AS CORONER ONLY --DID NOT SEE ALIVE 19__, to ____, 19__, ~~and I last saw the deceased alive~~ on ____ 19__, and that death occurred at 2 P m., from the causes and on the date stated above.

23a. SIGNATURE 583 E. Paris (Degree or title) CORONER	23b. ADDRESS 3720 Meadow Dr., Boise, Ida.	23c. DATE SIGNED 11/3/1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/3/1969	24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Nov. 5 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Paul Waggoner	LICENSE NO. E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

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NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4520
Local Reg. No. 145
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
NOV 3 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 10 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): MERIDIAN
d. STREET ADDRESS (If rural, give location): ROUTE 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	(NMI)	HOLCHIN	OCTOBER 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	APRIL 19, 1927	42		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MANAGER BOWLING LANES 26	RECREATION	SMOCK, PENNSYLVANIA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOSEPH C. HOLCHIN	GERMANY	LYDIA ARISON	PENNSYLVANIA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES POST KOREAN 8	179-24-6058	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4709

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute myocardial infarction	10 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute pulmonary conjestion	10 days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I last saw the deceased alive on OCTOBER 21, 19 69, and last attended the deceased from OCTOBER 31, 19 69, and that death occurred at 2:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
O.G. RIML, M.D. 591 [signature] (Degree or title)	VA CENTER, BOISE, IDAHO	11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-3-69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Myrtle Palmer	Erle B. Byram	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

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NOV 3 - 1969

NOV 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 1 2 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JAN 1 4 1970
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25. MAY 3 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4521
Local Reg. No. 816
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 13days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Bessie	Mae	Stephenson	October 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	married	May 27, 1918	51		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Horseshoe Bend, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Rood	Horseshoe Bend, Ida	Fannie Bessie Hill	Star. Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519 48 5444	X John L Stephenson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	4100 Myocardial infarction	10days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabeta-hypertension -	Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____ 19____, *to* DEATH, 19____, *that I last saw the deceased alive on* 31 Oct 69, 19____ *and that death occurred at* 12:00 noon *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lee Lilley MD 624	925 E 1st Meridian	4 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3	Nov. 4, 1969	Pioneer	Horseshoe Bend, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Myrtle Palmer	Glenn W Beatty	#392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

State File No. 4522
Local Reg. No. 329
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 030	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Marsh Valley Hospital 020	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) JULIA	b. (Middle) ANN	c. (Last) DENNEY	4. DATE OF DEATH (Month) (Day) (Year) Sept. 13, 1969	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan. 19, 1873	9. AGE (In years last birthday) 96 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Tooele, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John England	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Eliza Kennington	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) XXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE J. Boyd Denney	ADDRESS Blackfoot, Idaho	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) ~~myocardial infarction~~

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis
DUE TO (c) arteriosclerotic heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1951, *to* Sept. _____, 1969, *that I last saw the deceased alive on* Sept. 13, 1969, *and that death occurred at* 9:05 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE 070 [signature] (Degree or title)	23b. ADDRESS Downey Id	23c. DATE SIGNED 10.14.69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 16, 1969	24c. NAME OF CEMETERY OR CREMATORY Downey Cemetery	24d. LOCATION (City, town, or county) (State) Downey, Bannock, Idaho
DATE REC'D BY LOCAL REG. 10-16-69	REGISTRAR'S SIGNATURE Ila Mae Cunningham	25. EMBALMER	LICENSE NO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969
FEB 8 1972
JUN 22 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4523
Local Reg. No. 331
Reg. Dist. No. 510

69-927
BIRTH NO.

RECEIVED
STATE OF IDAHO
OCT 28 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1331 Yellowstone Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1331 Yellowstone Avenue - #28

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LON	SHANE	SCHROEDER	Sept. 29 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	January 10, 1969		9	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant C2	*****	Twin Falls, Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mark Schroeder	Twin Falls, Idaho	Peggy Denton	Twin Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	*****	*****	Mark Schroeder	Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7427

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH: from birth

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* [illegible], *that I last saw the deceased alive on* Sept. 29, 19 69, *and that death occurred at* 8:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 553 #	Bannock County Coroner	Pocatello, Idaho	Sept. 30, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 1, 1969	Twin Falls Cemetery	Twin Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 27 1969	[signature]	[signature]	E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4524
Local Reg. No. 332
Reg. Dist. No. 511

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malta
d. STREET ADDRESS (If rural, give location): R.F.D.

3. NAME OF DECEASED (Type or Print)
a. (First): Pearl
b. (Middle): O.
c. (Last): Hutchison

4. DATE OF DEATH (Month) (Day) (Year): October 1, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 30, 1892
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: House work
11. BIRTHPLACE (State or foreign country): Paradise, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas R. Smith — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Emma Obray — BIRTHPLACE: Paradise, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): * * *
16. SOCIAL SECURITY NO.: 519-01-6745-B
17. INFORMANT'S OWN SIGNATURE: Odell Hutchison — ADDRESS: Star Rt. Weeks Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial infarction	few minutes
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic heart disease with congestive heart failure	several yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus—mild	several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 23, 1956, *to* Oct 1, 1969, *that I last saw the deceased alive on* Oct 1, 1969, *and that death occurred at* 11:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John E Comstock 101 J E Comstock, MD
23b. ADDRESS: Box 852-Pocatello-Idaho
23c. DATE SIGNED: 10-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Oct. 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: Malta Cemetery
24d. LOCATION (City, town, or county) (State): Malta, Idaho

DATE REC'D BY LOCAL REG.: OCT 27 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: John P. Gassner
LICENSE NO.: E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Anderson

Certificate of Death

STATE OF IDAHO

State File No. 4525
Local Reg. No. 311
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
OCT 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: DOA-St.Anthony Community Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 435 So. 19th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DAVID	K.	MOFFAT	Oct. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 4,1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Budget Director 08	State of Utah	Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Millen A. Moffat	Unknown	Mary Kimball	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	529-09-2359	Mrs Ruth Larsen	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4119

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic heart disease with coronary insufficiency. Heart block. — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* October 14, 1966, *to* October 1, 1969, *that I last saw the deceased alive on* October 1, 1969, *and that death occurred at* 1:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	1448 E. Center, P.O. Box 4884	10-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Oct. 4,1969	Wasatch Lawn Cem.	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 6 1969	Blonia Dopita	John P Gorman	E-292

FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Meller

Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 4526
Local Reg. No. 374
Reg. Dist. No. 510

BIRTH NO.

OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 032
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello; LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Community Hospital 019	d. STREET ADDRESS (If rural, give location) Juniper Hill Drive

3. NAME OF DECEASED (Type or Print) a. (First) ALBERTA	b. (Middle) M.	c. (Last) ZWEIGART	4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 20, 1910	9. AGE (In years last birthday) 58 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec-Treas. 19	10b. KIND OF BUSINESS OR INDUSTRY Meat Packing Co.	11. BIRTHPLACE (State or foreign country) Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred A. Zweigart	BIRTHPLACE Germany	14. MOTHER'S MAIDEN NAME Margaret Gray	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-09-8723	17. INFORMANT'S OWN SIGNATURE Fred Zweigart	ADDRESS Pocatello, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1519

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) with abd. Metastasis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1968	19b. MAJOR FINDINGS OF OPERATION Ca of Stomach	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1968, 19__, *to* 10-1-, 19 69, *that I last saw the deceased alive on* 10-1-, 1969, *and that death occurred at* 4:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE 362 David C. Miller M.D. (Degree or title)	23b. ADDRESS Pocatello Idaho	23c. DATE SIGNED 10-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 4, 1969	24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.	24d. LOCATION (City, town, or county) (State) Pocatello, Idaho
DATE REC'D BY LOCAL REG. OCT 10 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER John P. Gronner	LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 6 1969

JUN 2 2 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 10 1969 Bureau of Vital Statistics

State File No. 4527
Local Reg. No. 312
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Bannock Mem.Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Route #3 South

3. NAME OF DECEASED (Type or Print)
a. (First) RODNEY
b. (Middle) RAY
c. (Last) PALMER

4. DATE OF DEATH (Month) (Day) (Year) October 2, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH May 11, 1968
9. AGE (In years last birthday) 1
IF UNDER 1 YR. Months 4 Days 21
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02
10b. KIND OF BUSINESS OR INDUSTRY XXXXX
11. BIRTHPLACE (State or foreign country) Ogden, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Karl Orlo Palmer
BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Carma Lee Mathews
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) XXXX
16. SOCIAL SECURITY NO. XXXX
17. INFORMANT'S OWN SIGNATURE Karl Orlo Palmer
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8207

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Fractures, Multiple, Skull vault and Base.

INTERVAL BETWEEN ONSET AND DEATH Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Driveway, Home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 13030 (STATE) Bannock Idaho.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-2-69 1:20 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car backed over child.

22. *I hereby certify that I attended the deceased from* —, 19__, *to* —, 19__, *that I saw the deceased* dead. *on* 10-2-69, *and that death occurred at* 1:20 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Burton H John 583 (Degree or title) Coroner
23b. ADDRESS Bannock Co Ida.
23c. DATE SIGNED 10-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct.8,1969
24c. NAME OF CEMETERY OR CREMATORY Inkom Cemetery
24d. LOCATION (City, town, or county) (State) Inkom, Bannock, Idaho

DATE REC'D BY LOCAL REG. OCT 7 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER Theron Miller
LICENSE NO. E-524

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 10 1969

NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4528
Local Reg. No. 315
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (If not in place) years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 542 No. 10th Ave. 000	d. STREET ADDRESS (If rural, give location) 542 No. 10th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) EDNA	b. (Middle) A	c. (Last) JOHNSON	4. DATE OF DEATH (Month) (Day) (Year) Oct. 3 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 10, 1883	9. AGE (In years last birthday) 85 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Chicago, Ill.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Armatis S. Holland	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Harriet Harvey	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-09-8210D	17. INFORMANT'S OWN SIGNATURE George R. Johnson	ADDRESS Pocatello, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

470X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Cardiac failure	12 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute influenza	36 hrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1969, 19__, *to* 3 Oct, 1969, *that I last saw the deceased alive on* 3 Oct, 1969 *and that death occurred at* 6:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Clark T. Parkeyman (Degree or title) 406	23b. ADDRESS 343 W Lewis Pocatello Ida	23c. DATE SIGNED 9 Oct 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct 6, 1969	24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cem.	24d. LOCATION (City, town, or county) Pocatello (State) Idaho
DATE REC'D BY LOCAL REG. OCT 13 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER George W. Knott	LICENSE NO. E-409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4529
Local Reg. No. 323
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 OCT 17 1969
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Comm. Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 314 Skyline Dr.

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) EUGENE
c. (Last) SCHUTT

4. DATE OF DEATH (Month) Oct. (Day) 3 (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Sept. 30, 1913
9. AGE (In years last birthday) 56
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William J. Schutt
BIRTHPLACE Nebraska
14. MOTHER'S MAIDEN NAME Mary E. Williams
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-8848
17. INFORMANT'S OWN SIGNATURE Ruth Schutt
ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4410

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Dissecting aortic aneurism.
INTERVAL BETWEEN ONSET AND DEATH 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 16 *19*69*, to* Oct 3 *, 19*69*, that I last saw the deceased alive on* Oct 3 *19*69*, and that death occurred at* 10:45 p *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 009 (Degree or title) M.D.
23b. ADDRESS P. O. Box 4884 Pocatello, Idaho 83201
23c. DATE SIGNED 10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) Pocatello (State) Idaho

DATE REC'D BY LOCAL REG. OCT 15 1969
REGISTRAR'S SIGNATURE Gloria Dopeta
25. EMBALMER [signature]
LICENSE NO. 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4530
Local Reg. No. 330
Reg. Dist. No. 511

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 030 — OCT 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL--McCammon
LENGTH OF STAY (In this place): 55 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 miles So. of McCammon 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 03c
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL--McCammon
d. STREET ADDRESS (If rural, give location): Rural Rte., Box 133

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ALPHONSE	H	WAGENER	Oct.	3	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 27, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Framer--Rancher 04	Agriculture	Mirsch, Luxembourg	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin Wagener	Luxembourg	Katherine (Unk)	Luxembourg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No				

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19 57, *to* Oct 3, 19 69, *that I last saw the deceased alive on* 9-26, 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] D.O.	[illegible]	10/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 7, 1969	Mountainview Cem.	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-16-69	Ila Mae Cunningham	[signature]	409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 1 1969
JUL 2 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4531
Local Reg. No. 343
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 018 Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 468 West Pine

3. NAME OF DECEASED (Type or Print) a. (First) HARMON b. (Middle) PAUL c. (Last) CLINE

4. DATE OF DEATH (Month) (Day) (Year) Oct. 4, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Oct. 21, 1897

9. AGE (In years last birthday) 71
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor 10

10b. KIND OF BUSINESS OR INDUSTRY U.P.R.R.

11. BIRTHPLACE (State or foreign country) Joplin, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harmon Cline
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Mary Atkinson
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) XXXX

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Lola Hall
ADDRESS Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. (1) Emphysema (2) Lateral Femoral neck fracture.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) Pocatello, (COUNTY) Bannock (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 14, 1969, 1969, *to* Oct. 1, 1969, *that I last saw the deceased alive on* Oct. 1, 1969, *and that death occurred at* 11:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE Richard Elstad MD (Degree or title)

23b. ADDRESS 246 No. 18th

23c. DATE SIGNED 11/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct.10,1969

24c. NAME OF CEMETERY OR CREMATORY Glenn Rest Cemetery,

24d. LOCATION (City, town, or county) Glenns Ferry, (State) Idaho

DATE REC'D BY LOCAL REG. NOV 5 1969

REGISTRAR'S SIGNATURE Glenn Dopita

25. EMBALMER Theron Spilker

LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4532
Local Reg. No. 316
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1153 South Fourth Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): PETE
b. (Middle):
c. (Last): MARTINOFF

4. DATE OF DEATH (Month) (Day) (Year): October 4 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Not known
8. DATE OF BIRTH: June 11, 1880
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheepherder 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Alaska
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: No data — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: No data — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 720-03-9398
17. INFORMANT'S OWN SIGNATURE: Personal records — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Antecedent to heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 20, 1969, *to* Oct. 4, 1969, *that I last saw the deceased alive on* Oct. 4, 1969, *and that death occurred at* 10:40p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 113 mb
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Oct. 9, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: OCT 13 1969
REGISTRAR'S SIGNATURE: Gloria Dopeta
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4533
Local Reg. No. 327
Reg. Dist. No. 5-10

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
OCT 23 1969

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1099 Allen Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JACQUELINE	BELLE	SMITH	Oct. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced	Sept.22,1927	42		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Ashton, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David E. Meeks	Utah	Mabel Birch	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No / XXXX		x Mrs Mabel Meeks	Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5719

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cirrhosis of the Liver — INTERVAL BETWEEN ONSET AND DEATH: Several months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Malnutrition
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9-8, 1969, to 10-4, 1969, that I last saw the deceased alive on 10-4, 1969, and that death occurred at 11 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M Woman MD	Pocatello, Idaho	10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct.8,1969	Restlawn Mem.Gardens	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 21 1969	Gloria Dopita	Theron Smiller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4534
Local Reg. No. 333
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031 OCT 28 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello Bureau of Vital Statistics c. LENGTH OF STAY (In this place) 10 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Comm. Hosp 019	d. STREET ADDRESS (If rural, give location) 515 E. Halliday

3. NAME OF DECEASED (Type or Print)	a. (First) GUY	b. (Middle) R	c. (Last) VALENTINE	4. DATE OF DEATH (Month) Oct.	(Day) 4	(Year) 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 25,1890	9. AGE (In years last birthday) 79	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 22	10b. KIND OF BUSINESS OR INDUSTRY Grodery	11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Nick Valentine	BIRTHPLACE Italy	14. MOTHER'S MAIDEN NAME Ann Caputo	BIRTHPLACE Italy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-42-8663	17. INFORMANT'S OWN SIGNATURE Rosa Valentine	ADDRESS Pocatello, Idaho			

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial infarction, recurrent	few minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease with immediate preceding infarction occurring approximately ten days prior to death	several months
DUE TO (c)		several years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus—mild	several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 3, 1963, *to* Oct. 4, 1969, *that I last saw the deceased alive on* Oct. 4, 1969, *and that death occurred at* 6:55p *m., from the causes and on the date stated above.*

23a. SIGNATURE J E Comstock 101 (Degree or title) J E Comstock, MD	23b. ADDRESS Box 852-Pocatello-Idaho	23c. DATE SIGNED 10-22-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct.7,1969	24c. NAME OF CEMETERY OR CREMATORY Mountainview	24d. LOCATION (City, town, or county) Pocatello (State) Idaho
DATE REC'D BY LOCAL REG. OCT 27 1969	REGISTRAR'S SIGNATURE Gloria Dopeta	25. EMBALMER George W. Knopp	LICENSE NO. 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4535
Local Reg. No. 334
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 OCT 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) years
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 240 Valleyview Dr. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 240 Valleyview Dr.

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) F c. (Last) DOWNEY

4. DATE OF DEATH (Month) Oct. (Day) 5 (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Mar. 21, 1914
9. AGE (In years last birthday) 55
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10 Locomotive Engineer
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Lagootee, Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James C. Downey BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Lucy L. Carrico BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-07-9387
17. INFORMANT'S OWN SIGNATURE Marel Downey ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severe Arterio-Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cirrhosis of liver - Severe. ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — *, 19*__*, to* — *, 19*__*, that I last saw the deceased alive* dead. *on* 10-5-69 *, 19*__*, and that death occurred at* 12:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Benton J. Hahn 553 (Degree or title) Coroner
23b. ADDRESS Bannock Co. Ida.
23c. DATE SIGNED 10-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 8, 1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) Pocatello (State) Idaho

DATE REC'D BY LOCAL REG. OCT 27 1969
REGISTRAR'S SIGNATURE Gloria Dopeta
25. EMBALMER George W Knapp
LICENSE NO. 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969

NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4536
Local Reg. No. 322
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 27 Greenwood Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 27 Greenwood Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ETHEL	MAUDE	FARMER	October 5 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	January 6, 1903	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	McCammon Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Patrick Barron	Ireland	Cynthia Stewart	Farmington, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	*****	519-12-6311	Rae E. Farmer	Pocatello, Idaho

4409

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Natural Causes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) General Arteriosclerosis 3 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Pocatello Bannock Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, to Oct 5, 1969, *that I last saw the deceased alive on* Aug 12, 1969, *and that death occurred at* 4A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Pocatello, Idaho	10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 7, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 14 1969	Elora Dopita	Jack Henderson	E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 4537
Local Reg. No. 324
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031 OCT 17 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello Bureau of Vital Statistics; c. LENGTH OF STAY (In this place) 1 wk	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Comm. Hosp. 019	d. STREET ADDRESS (If rural, give location) 1323 E. Lander

3. NAME OF DECEASED (Type or Print) a. (First) EARL	b. (Middle) D	c. (Last) STANDIFORD	4. DATE OF DEATH (Month) Oct. (Day) 5 (Year) 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 24, 1888	9. AGE (In years last birthday) 80 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer 10	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Dola, Ohio	12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Frank Standiford	BIRTHPLACE Ohio	14. MOTHER'S MAIDEN NAME Margaret DeLacey	BIRTHPLACE Ohio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I 3	16. SOCIAL SECURITY NO. 712-07-2207	17. INFORMANT'S OWN SIGNATURE Mrs Roy Mann	ADDRESS Richmond, Calif	

18. CAUSE OF DEATH 7070
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Decubitus ulcer	6 mo
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Malnutrition	1 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 25, 1969, *to* 10-5, 1969, *that I last saw the deceased alive on* Oct 5, 1969, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 113 (Degree or title) MD	23b. ADDRESS Pocatello Idaho	23c. DATE SIGNED 10-10-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct 8, 1969	24c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cem.	24d. LOCATION (City, town, or county) Pocatello (State) Idaho
DATE REC'D BY LOCAL REG. OCT 16 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER George W. Knoth	LICENSE NO. 409

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 0 1969
OCT 2 4 1969
AUG 2 8 1996

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4538
Local Reg. No. 325
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 — OCT 17 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 6 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 294 Hillcrest Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 630 Willard Ave.

3. NAME OF DECEASED (Type or Print): a. (First) LUCY — b. (Middle) TRAHANT — c. (Last) FORSTER

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 25, 1877

9. AGE (In years last birthday): 91
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Manitoba, Canada

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Abner A. Maywood — BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Sarah Alesworth — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Ellen Cook — ADDRESS: Pocatello Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* any, 19 69, *to* Oct 6, 19 69, *that I last saw the deceased alive on* 6 Oct, 19 69, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: R.L. Randall 113 (Degree or title): M.D.

23b. ADDRESS: 804 E. Center Pocatello

23c. DATE SIGNED: 10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 9, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.

24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: OCT

REGISTRAR'S SIGNATURE: Elona Depita

25. EMBALMER: George W. Knopp — LICENSE NO.: 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 2 0 1969
NOV 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4539
Local Reg. No. 319
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 219 North Grant

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THOMAS	A.	HUFF	Oct. 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married	Mar.5,1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Ordnance Plant 09
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lewiston, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thaddeus Thomas Huff	Georgia	Frances Russell	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXX	519 07 4153	Rosa Huff	Pocatello, Idaho

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Sudden death — Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic HT dis — 3 years
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Intrinsic asthma — 15 years

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1956, 19__, *to* Oct 6, 19 69, *that I last saw the deceased alive on* Oct. 5, 19 69 *and that death occurred at* 6 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible]	Pocatello	10-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct.9,1969	Newdale-Teton Cemetery	Teton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 14 1969	Florence Dopita	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4540
Local Reg. No. 320
Reg. Dist. No. 510

BIRTH NO.

RECEIVED Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 — OCT 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 723 North Hayes

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GOLDEN	DEVERE	THYBERG	Oct. 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married	Sept.23,1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
10	P.F.E.	Arbon, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Rudolph Thyberg	Utah	Martha Jane Iverson	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War II		Anna L. Thyberg	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) ~~Liver~~ Coma (Hepatic) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cirrhosis of the liver
DUE TO (c) Chronic Alcoholism

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

5710

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 5, 1969, *to* Oct 6, 1969, *that I last saw the deceased alive on* Oct 6, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Calvin Bibler 069 M.D.		10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct.9,1969	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 14 1969	Gloria Dopita	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4541
Local Reg. No. 322
Reg. Dist. No. 510

BIRTH NO.

RECEIVED Bureau of Vital Statistics OCT 17 1969

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Comm. Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 72 Rosewood Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EUGENE	BEARNARD	KEARNS	Oct. 7 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Nov. 27, 1896	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman 16	Fruit Express Co.	Marshalltown, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward J. Kearns	Ireland	Mary Ann Burns	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW I 3	700-18-0109	Mrs E.B. Kearns	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 5329 Bronchial ulcer		2 mo
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Emphysema - left lung		2 mos

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 15 Sept, 1969, to 7 Oct, 1969, *that I last saw the deceased alive on* 7 Oct, 1969, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R.L. Randall MD	Pocatello Idaho	10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 10, 1969	Mountainview	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 16 1969	Gloria Rapita	George W. Knott	409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 0 1969

DEC 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 6 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
NOV 7 1969
BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 4542
Local Reg. No. 344
Reg. Dist. No. 511

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Butte 120
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Arco
d. STREET ADDRESS (If rural, give location): 1 mile South

3. NAME OF DECEASED (Type or Print): a. (First) RALPH b. (Middle) ELMER c. (Last) KIRKPATRICK
4. DATE OF DEATH (Month) (Day) (Year): October 7, 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 5, 1916
9. AGE (In years last birthday): 53 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 54
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Grover C. Kirkpatrick BIRTHPLACE: Blackfoot, Ida.
14. MOTHER'S MAIDEN NAME: Emily Miller BIRTHPLACE: Blackfoot, Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W. W. II 4
16. SOCIAL SECURITY NO.: 518-10-7669
17. INFORMANT'S OWN SIGNATURE: X Evelyn B Kirkpatrick ADDRESS: Arco Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4389

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary and cerebral edema, severe. — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Arteriosclerotic heart disease. — 5 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 67, *to* Oct. 7, 19 69, *that I last saw the deceased alive on* Oct. 7, 1969 *and that death occurred at* 4:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. H. Anderson, M. D. 007
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Oct. 14, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-11-69
24c. NAME OF CEMETERY OR CREMATORY: Grove City
24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: OCT 31 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349
FIRM NAME: Henderson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 10 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 13 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4543
Local Reg. No. 345
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
NOV 7 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 031
b. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 591 Ridge

3. NAME OF DECEASED (Type or Print)
a. (First): TRUMAN
b. (Middle): CALL
c. (Last): BARLOW

4. DATE OF DEATH (Month) (Day) (Year): Oct. 10, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 28, 1879

9. AGE (In years last birthday): 89
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 054

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Bountiful, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Truman Heap Barlow
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Fannie Call
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary arteriosclerosis with congestive heart failure. Pulmonary edema. — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1962 *to* October 10, 1969 *that I last saw the deceased alive on* October 10, 1969 *and that death occurred at* 6:38 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)
L. H. Anderson, M.D. 009

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: Nov. 4, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 18

24b. DATE: Oct. 14, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: NOV 5 [redacted]

REGISTRAR'S SIGNATURE: Elona Dopita

25. EMBALMER: Theron Miller

LICENSE NO.: E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4544
Local Reg. No. 335
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 OCT 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township place): Pocatello Bureau of Vital Statistics
c. LENGTH OF STAY: 2 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): rural area at Marysville

3. NAME OF DECEASED (Type or Print)
a. (First): Veryl
b. (Middle): Wayne
c. (Last): Huntsman

4. DATE OF DEATH (Month) (Day) (Year): October 10, 1969

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Nov 21, 1940
9. AGE (In years last birthday): 28 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronics 21
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (State or foreign country): Marysville, Fremont Co., Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lionel Huntsman — BIRTHPLACE: Marysville, Idaho
14. MOTHER'S MAIDEN NAME: Iona J. Moon — BIRTHPLACE: St. Anthony, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): 1958 - 1961 8
16. SOCIAL SECURITY NO.: 518-48-1093
17. INFORMANT'S OWN SIGNATURE: X Lionel Huntsman — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Osteogenic sarcoma metastatic to lung, brain, and other soft tissues — INTERVAL BETWEEN ONSET AND DEATH: app 19 mns

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 11, 1969, *to* Oct 10, 1969, *that I last saw the deceased alive on* Oct 10, 1969, *and that death occurred at* 3:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE: J E Comstock (Degree or title): J E Comstock, MD
23b. ADDRESS: Box 852-Pocatello-Idaho
23c. DATE SIGNED: 10-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Idaho

DATE REC'D BY LOCAL REG.: OCT 27 [illegible]
REGISTRAR'S SIGNATURE: Gloria Dopeta
25. EMBALMER: Jack Henderson
LICENSE NO.: E-349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robert Bean Funeral Home, Ashton, Ida

DUTIES:

OCT 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4545
Local Reg. No. 346
Reg. Dist. No. 510

BIRTH NO.

RECEIVED NOV 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Bannock Mem. Hospital 018	d. STREET ADDRESS (If rural, give location): 835 South Fifth Avenue

3. NAME OF DECEASED (Type or Print) a. (First): TERRY	b. (Middle):	c. (Last): STAFFORD	4. DATE OF DEATH (Month) (Day) (Year): Oct 11 '69	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married	8. DATE OF BIRTH: Sept.23,1969	9. AGE (In years last birthday): IF UNDER 1 YR. Months Days 17; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02	10b. KIND OF BUSINESS OR INDUSTRY: XXXX	11. BIRTHPLACE (State or foreign country): Jackson Hole, Wyo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Tony Stafford	BIRTHPLACE: Idaho	14. MOTHER'S MAIDEN NAME: Nita Jensen	BIRTHPLACE: Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): XXX	16. SOCIAL SECURITY NO.: XXX	17. INFORMANT'S OWN SIGNATURE: Tony Stafford	ADDRESS: Pocatello	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

9111X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) aspiration of stomach contents — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Oct 7, 1969, *to* Oct 10, 1969, *that I last saw the deceased alive on* Oct 10, 1969, *and that death occurred at* ? A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Roger W. Bor MD (Degree or title) 011	23b. ADDRESS: 527 S. 12	23c. DATE SIGNED: 3 Nov 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct.13,1969	24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery	24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho
DATE REC'D BY LOCAL REG.: NOV 1969	REGISTRAR'S SIGNATURE: Gloria Dopita	25. EMBALMER: Theron Miller	LICENSE NO.: E-594

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4546
Local Reg. No. 324
Reg. Dist. No. 511

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Inkom
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital
d. STREET ADDRESS (If rural, give location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Inkom
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): PEARL
b. (Middle): M.
c. (Last): BALL

4. DATE OF DEATH (Month) (Day) (Year): October 12 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: September 9, 1898
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing 13
10b. KIND OF BUSINESS OR INDUSTRY: Registered Nurse
11. BIRTHPLACE (State or foreign country): Choestoe, Georgia
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: A. N. Miller — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Etta Nix — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: 722-18-1059
17. INFORMANT'S OWN SIGNATURE: Frank Ball — ADDRESS: Inkom, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro Vascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebro atherosclerose
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-20, 1969, *to* Oct. 12, 1969, *that I last saw the deceased alive on* Oct. 12, 1969, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): N Wonnen 774
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: Oct. 15, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: OCT 20 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4547
Local Reg. No. 336
Reg. Dist. No. 511

BIRTH NO.

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location) Buckskin Road

3. NAME OF DECEASED (Type or Print)	a. (First) CHARLES	b. (Middle) BRADLEY	c. (Last) SKENANDORE	4. DATE OF DEATH (Month) (Day) (Year) Oct. 12, 1969
5. SEX Male	6. COLOR OR RACE Indian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 5,1942	9. AGE (In years last birthday) 27 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equipment Op. 21	10b. KIND OF BUSINESS OR INDUSTRY Simplots	11. BIRTHPLACE (State or foreign country) Schurz, Nevada	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Skenandore	BIRTHPLACE Wisconsin	14. MOTHER'S MAIDEN NAME Diane Najor	BIRTHPLACE Nevada	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1962-1964 8	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Marion Carol Skenandore	ADDRESS	

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Unable to give exact diagnosis as no autopsy was allowed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT X SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) S Street 04	21c. (CITY, TOWN, OR TOWNSHIP) Pocatello, Bannock 13031 (COUNTY) Idaho (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 12, 1969 6:00 PM	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR? Auto accident	

22. *I hereby certify that I attended the deceased from* Oct. 12, 1969, 19__, *to* Oct. 12, 1969, 19__, *that I last saw the deceased alive on* Oct. 12, 1969, 19__, *and that death occurred at* 10:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE A. W. McRoberts 867 (Degree or title) M.D.	23b. ADDRESS 1448 East Center	23c. DATE SIGNED 10/20/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Crypt burial 3	24b. DATE Oct.16,1969	24c. NAME OF CEMETERY OR CREMATORY Shrine of Memories	24d. LOCATION (City, town, or county) Salt Lake City, (State) Utah
DATE REC'D BY LOCAL REG. OCT	REGISTRAR'S SIGNATURE Gloria Dopette	25. EMBALMER Leon Manning Jr.	LICENSE NO. E-537

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969

NOV 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 5 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 1 4 1986

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4548
Local Reg. No. 327
Reg. Dist. No. 570

BIRTH NO.

RECEIVED STATE OF IDAHO

NOV 7 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN: Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 014

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 421 South Fourth Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): LUCYLLE
b. (Middle): ELIZABETH
c. (Last): OXLEY

4. DATE OF DEATH: (Month) October (Day) 13 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: January 21, 1913

9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Blue Mound Kansas

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Ray E. Talbott
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Rhea Longdon
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 518-12-2731

17. INFORMANT'S OWN SIGNATURE: Ralph L. Oxley
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral vascular accident
INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 11, 1969, *to* Oct. 13, 1969, *that I last saw the deceased alive on* Oct. 13, 1969, *and that death occurred at* 5:58a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 009. (Degree or title) MD
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: NOV 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: E - 348

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 21 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4549
Local Reg. No. 337
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031 OCT 28 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello Bureau of Vital Statistics c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 837 W. Benton 000	d. STREET ADDRESS (If rural, give location) 837 W. Benton

3. NAME OF DECEASED (Type or Print)	a. (First) LENORE	b. (Middle) GRADY	c. (Last) SMITH	4. DATE OF DEATH (Month) (Day) (Year) Oct. 14, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 24, 1902	9. AGE (In years last birthday) 67 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward F. Grady	BIRTHPLACE South Dakota	14. MOTHER'S MAIDEN NAME Anna Francis Bowman	BIRTHPLACE Wisconsin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 528-09-1539D	17. INFORMANT'S OWN SIGNATURE Guy H. Smith	ADDRESS Pocatello, Idaho	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH sudden onset

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1966, *to* October 14, 1969, *that I last saw the deceased alive on* October 14, 1969, *and that death occurred at* 1:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Sydney A. Hornocks 733 (Degree or title) M.D.	23b. ADDRESS Pocatello, Idaho	23c. DATE SIGNED 10-24-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 17-69	24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.	24d. LOCATION (City, town, or county) (State) Pocatello, Idaho
DATE REC'D BY LOCAL REG. OCT 27 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER John P. Gorman	LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 28 1969 Bureau of Vital Statistics

State File No. 4550
Local Reg. No. 338
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF ... (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) MERLAND
b. (Middle) D.
c. (Last) LABRUM

4. DATE OF DEATH (Month) (Day) (Year) Oct. 15, 1969

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Mar.29, 1929
9. AGE (In years last birthday) 40
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction 11
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William B. Labrum
BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Hilma Edith Johnson
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) Korean Con. 6
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE X Mrs. Sylvia Labrum
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gunshot wound to the brain

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE X HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased ~~from~~ on October 15, 1969, to _____, 19____, that I last saw the deceased alive on October 15, 1969, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Calvin Buhler, M.D. 069 (Degree or title)
23b. ADDRESS Pocatello, Idaho
23c. DATE SIGNED 10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct.18,1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. OCT 27 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER Leon Manning
LICENSE NO. E-537

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

BIRTH NO. 69-3393

RECEIVED

STATE OF IDAHO

State File No. 4551
Local Reg. No. 339
Reg. Dist. No. 510

1. PLACE OF DEATH a. COUNTY: Bannock 031 OCT 28 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello — Bureau of Vital Statistics — c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019	d. STREET ADDRESS (If rural, give location): 643 South 9th Avenue

3. NAME OF DECEASED (Type or Print)	a. (First): DEBRA	b. (Middle): LYNN	c. (Last): RICKARD	4. DATE OF DEATH (Month) (Day) (Year): Oct. 16, 1969
5. SEX: Female	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married	8. DATE OF BIRTH: Apr.28,1969	9. AGE (In years last birthday): IF UNDER 1 YR. Months 5 Days 18; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02	10b. KIND OF BUSINESS OR INDUSTRY: xxxxx	11. BIRTHPLACE (State or foreign country): Pocatello, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Darrell Wayne Rickard	BIRTHPLACE: Idaho	14. MOTHER'S MAIDEN NAME: Karren Krohn	BIRTHPLACE: Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): xxxx	16. SOCIAL SECURITY NO.: xxxx	17. INFORMANT'S OWN SIGNATURE: Darrell Wayne Rickard	ADDRESS:	

18. CAUSE OF DEATH 7469
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Aspiration & pneumonia	8-10 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Congenital anomalies & probable congenital heart doses	from birth
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [✓] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on* Oct 16, 1969, *and that death occurred at* 8:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. T. Boyd 967 (Degree or title) MD	23b. ADDRESS: 577 S. 12th	23c. DATE SIGNED: 10-20-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct 18,1969	24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery	24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Ida.
DATE REC'D BY LOCAL REG.: OCT 2 1969	REGISTRAR'S SIGNATURE: Gloria Dopita	25. EMBALMER: Theron Miller	LICENSE NO.: E-524

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4552
Local Reg. No. 340
Reg. Dist. No. 510

BIRTH NO.

RECEIVED

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031 OCT 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 303 North Hayes

3. NAME OF DECEASED (Type or Print): a. (First) BLANCHE b. (Middle) ETHEL c. (Last) QUILLEN

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug.12, 1903

9. AGE (In years last birthday): 66
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Spearville, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Daniel Tolson
BIRTHPLACE: Pa.

14. MOTHER'S MAIDEN NAME: Ida Ollie Sprott
BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: H.O. Quillen
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1950

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hepatic insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Liver replacement by tumor — months
DUE TO (c) Advanced carcinomatosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Debility

19a. DATE OF OPERATION: 6/23/69

19b. MAJOR FINDINGS OF OPERATION: Intra-abdominal carcinomatosis

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 18, 19 69 *to* October 18, 19 69 *, that I last saw the deceased alive on* October 18, 19 69 *, and that death occurred at* 11:45P m., *from the causes and on the date stated above.*

23a. SIGNATURE: H.K. Staheli 443 (Degree or title): H.K.Staheli, M. D.

23b. ADDRESS: 246 N. 18, Pocatello, Idaho

23c. DATE SIGNED: 10/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct.21,1969

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem.Gardens

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 27 1969

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Thurman Quillen

LICENSE NO.: E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969
NOV 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4553
Local Reg. No. 341
Reg. Dist. No. 210

BIRTH NO.

RECEIVED OCT 28 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Nurs. Home 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 307 No. 14th

3. NAME OF DECEASED (Type or Print) a. (First) LUCILE b. (Middle) c. (Last) COMER

4. DATE OF DEATH (Month) (Day) (Year) Oct. 19, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH April 17, 1887

9. AGE (In years last birthday) 82

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Minnesota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Manself BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Theresia Myers BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-40-2738A

17. INFORMANT'S OWN SIGNATURE Elmer H. Comer ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1966, to Jan, 1969, that I last saw the deceased alive on Jan, 1969 and that death occurred at 7 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M D

23b. ADDRESS Pocatello Idaho

23c. DATE SIGNED 10-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 23-69

24c. NAME OF CEMETERY OR CREMATORY Aberdeen Cem

24d. LOCATION (City, town, or county) (State) Aberdeen, Idaho

DATE REC'D BY LOCAL REG. OCT 27 1969

REGISTRAR'S SIGNATURE Gloria Dopita

25. EMBALMER John P. Downard

LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Publication Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969

MAY 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended December 4, 1969

Certificate of Death
STATE OF IDAHO

State File No. 4554
Local Reg. No. 342
Reg. Dist. No. 511

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Inkom
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Albert; b. (Middle) Ruben; c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year): October 20, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: April 11, 1900

9. AGE (In years last birthday): 69
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Surveyor 27

10b. KIND OF BUSINESS OR INDUSTRY: Surveying

11. BIRTHPLACE (State or foreign country): Hatch, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Thomas Williams
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Hannah Detton
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXX

16. SOCIAL SECURITY NO.: 557-10-5334

17. INFORMANT'S OWN SIGNATURE: Mrs. Helene McMullen
ADDRESS: California

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fractured rib & Fracture rt knee — 2 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): XX / i / Auto
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 60832

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 18, 1969 9p m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ XX
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 19, 19 69, *to* Oct 20, 19 69, *that I last saw the deceased alive on* Oct 20, 19 69, *and that death occurred at* 6p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. G. Crandall, M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: Oct 27, 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Theron S. Miller
LICENSE NO.: E 524

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
DEC 4 1969
Bureau of Vital Statistics

State of Idaho
County of Bannock } ss.

Certificate No. 69-4554

Date Filed

The undersigned does solemnly swear that certain facts in the certificate of death (Birth or Death)
for Albert Ruben Williams (Name on Original Certificate) who died (Was Born or Died) on Oct 20, 1969 (Date of Event)
in Pocatello, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#14 Mother's Name	Hanna Detton	Hannah Detton
# 7	Never married	Divorced

Subscribed and sworn to before me this 1st day of December, 1969

Notary Public, residing at Pocatello, Idaho
My commission expires Dec. 1970
(Seal)

Signed [signature]
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)
136 East Clark, Pocatello, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Bannock } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 1st day of December, 1969

Notary Public, residing at Pocatello, Idaho
My commission expires Dec. 1970
(Seal)

Signed [signature]
(Signature of Any Credible Person)
614 North 10th, Pocatello, Idaho
(Street Address, City, State)

FORM DH 60-155

[redacted]

Certificate of Death

STATE OF IDAHO

State File No. 4554
Local Reg. No. 342
Reg. Dist. No. 511

BIRTH NO.

RECEIVED OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Inkom
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) ALBERT; b. (Middle) RUBEN; c. (Last) WILLIAMS

4. DATE OF DEATH (Month) (Day) (Year): Oct. 20, 1969

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: April 11, 1900

9. AGE (In years last birthday): 69
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Surveyor

10b. KIND OF BUSINESS OR INDUSTRY: Surveying

11. BIRTHPLACE (State or foreign country): Hatch, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Thomas Williams
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Hanna Detton
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): xxx

16. SOCIAL SECURITY NO.: 557 10 5334

17. INFORMANT'S OWN SIGNATURE: Mrs Helene M Mullen
ADDRESS: California

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 20 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fractured rib & fractures at knee — 20 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): auto
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 18 64 9 p.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 19, 19 64, to Oct 20, 19 64, that I last saw the deceased alive on Oct 20, 19 64, and that death occurred at 6 p.m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Pocatello Ida
23c. DATE SIGNED: 10-24-64

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 27 1969
REGISTRAR'S SIGNATURE: Ilona Dosta
25. EMBALMER: Theron Spiller
LICENSE NO.: E-524
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 4 1969
DEC 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4555
Local Reg. No. 348
Reg. Dist. No. 511

Certificate of Death

RECEIVED NOV 7 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BANNOCK 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): DOWNEY
c. LENGTH OF STAY (in this place): 3 weels
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: BANNOCK 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LAVA HOT SPRINGS
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ERMA
b. (Middle): DEL
c. (Last): SNYDER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 22, 1969

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 6, 1879
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months 4, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cyrus A. Warner — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Abigale Tyler — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 539-14-5895
17. INFORMANT'S OWN SIGNATURE: Mrs Gladys Sanderson — ADDRESS: Am. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Vascular accident
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1958, *to* Oct 22, 1969 *that I last saw the deceased alive on* Oct 22, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 070
23b. ADDRESS: Downey Id
23c. DATE SIGNED: 10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial 3
24b. DATE: 10-25-69
24c. NAME OF CEMETERY OR CREMATORY: Fallsview Cemetery
24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: 10-28-69
REGISTRAR'S SIGNATURE: Ila Mae Cunningham
25. EMBALMER: H. L. Davis — LICENSE NO.: H. L. Davis E-253
FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4556
Local Reg. No. 349
Reg. Dist. No. 510

BIRTH NO. 69-9882

RECEIVED NOV 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital EIS

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 3625 McKinley

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RANDALL	JAMES	AVERY	October 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	never married	Oct. 20, 1969		3	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant 07	xxx	Pocatello, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ray G. Avery	Pocatello, Idaho	Myrld Williams	Pocatello Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	xxx	xxx	Ray G Avery	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7720

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 20 1969 to Oct 23, 1969, that I last saw the deceased alive on Oct 23, 1969, and that death occurred at 4:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. [illegible] M.D.	Theron Miller	11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 25, 1969	Lava Hot Springs Cem.,	Lava Hot Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 5 1969	Gloria Doppelt	Theron Miller	E 524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4557
Local Reg. No. 350
Reg. Dist. No. 510

BIRTH NO.

RECEIVED Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Bannock 03 NOV 7 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 556 West Fremont

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PAUL	ADAMS	WEIL	Oct. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married	Dec. 27, 1889	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter and Saw Mill		Onarga, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Bernard Weil	Germany	Annie Elizabeth Jones	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No XXX		Lon L. Harris	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral vascular accident — 4369 — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April 1 *, 19* 69 *, to* October 25 *, 19* 69 *, that I last saw the deceased alive on* October 25 *, 19* 69 *, and that death occurred at* 2:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
0069 M.D.	1448 E. Center, P. O. Box 4884, Pocatello, Idaho	10-30-6

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. Burial 3	Oct. 27, 1969	Burns Cemetery	Burns, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 3 1969	Gloria Dopita	Theron Miller	E-334

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4558
Local Reg. No. 351
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Rest Home 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 835 North 11th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) LAURA
b. (Middle)
c. (Last) DALLANCOURT

4. DATE OF DEATH (Month) (Day) (Year) Oct. 28, 1969

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Oct. 16, 1898
9. AGE (In years last birthday) 71
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Oxford, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert C. Lewis
BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Marieama Anderson
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) XXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Guy Dallancourt
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral thrombosis
INTERVAL BETWEEN ONSET AND DEATH 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1967, 19__, *to* Oct 28, 1969, *that I last saw the deceased alive on* Oct 28, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 113 (Degree or title)
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct.31,1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. NOV 3 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER Theron Miller
LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4559
Local Reg. No. 352
Reg. Dist. No. 511

BIRTH NO. 69-9908

RECEIVED NOV 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location) Route #3 South Box 239

3. NAME OF DECEASED (Type or Print) a. (First) RICHARD	b. (Middle) WILLIAM	c. (Last) PALMER	4. DATE OF DEATH (Month) (Day) (Year) Oct. 29, 1969	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Oct. 26,1969	9. AGE (In years last birthday) IF UNDER 1 YR. Months Days 3 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02	10b. KIND OF BUSINESS OR INDUSTRY xxx	11. BIRTHPLACE (State or foreign country) Pocatello, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Karl Orlo Palmer	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Carma Lee Mathews	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) xxx	16. SOCIAL SECURITY NO. xxx	17. INFORMANT'S OWN SIGNATURE Karl Orlo Palmer	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7762

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) respiratory distress syndrome — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth *, 19__, to* Oct 29 *, 19* 69 *, that I last saw the deceased alive on* Oct 29 *, 19*69 *, and that death occurred at* 5:30 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE 671 Ragiele Bore MD (Degree or title)	23b. ADDRESS 527 S. 12	23c. DATE SIGNED 10/29/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov.1,1969	24c. NAME OF CEMETERY OR CREMATORY Inkom Cemetery	24d. LOCATION (City, town, or county) (State) Inkom, Bannock, Idaho
DATE REC'D BY LOCAL REG. NOV 5 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Theron Miller	LICENSE NO. E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4560
Local Reg. No. 383
Reg. Dist. No. 5-10

BIRTH NO.

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN Pocatello
c. LENGTH OF STAY IN THIS CITY OR TOWN
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Community Hospital 379

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 318 North Third Avenue

3. NAME OF DECEASED (Type or Print) a. (First) WALTER b. (Middle) c. (Last) HUDSON

4. DATE OF DEATH (Month) (Day) (Year) October 30 1969

5. SEX Male

6. COLOR OR RACE Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH February 22, 1887

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner - Operator 22

10b. KIND OF BUSINESS OR INDUSTRY Tavern

11. BIRTHPLACE (State or foreign country) Burton Texas

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Alfred Hudson
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Mary (no data)
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) *****

16. SOCIAL SECURITY NO. 518-36-3216

17. INFORMANT'S OWN SIGNATURE Mrs Amanda Hudson ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5990

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Infection — Years
DUE TO (c) Senility — 1 Year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10/23/69

19b. MAJOR FINDINGS OF OPERATION Urinary Retention & infection

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) Pocatello (COUNTY) Bannock (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 12, 1969, *to* Oct. 30, 1969, *that I last saw the deceased alive on* Oct. 30, 1969, *and that death occurred at* 6:30a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) C C Groom, M.D

23b. ADDRESS Pocatello, Idaho

23c. DATE SIGNED Oct. 31, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 3, 1969

24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery

24d. LOCATION (City, town, or county) Pocatello (State) Idaho

DATE REC'D BY LOCAL REG. NOV 7 1969

REGISTRAR'S SIGNATURE Ilona Dopita

25. EMBALMER Jack Henderson

LICENSE NO. E - 348

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4561
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
OCT 14 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hosp. 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Colorado 06
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elbert
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Harry
b. (Middle): L.
c. (Last): Morgan

4. DATE OF DEATH (Month) (Day) (Year): Oct. 3 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 6, 1926
9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): truck driver 27
10b. KIND OF BUSINESS OR INDUSTRY: Candies Russell Stover
11. BIRTHPLACE (State or foreign country): DesMoines, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lyle Mor gan — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Mildred Stinson — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): World War II 4
16. SOCIAL SECURITY NO.: 536-18-9910
17. INFORMANT'S OWN SIGNATURE: Ellene McGrath Morgan — ADDRESS: Elbert, Colo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Montpelier Bear Lake Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 Oct, 1969, *to* 3 Oct, 1969, *that I last saw the deceased alive on* 3 Oct, 1969, *and that death occurred at* 10:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: J W Schoper MD 458 (Degree or title)
23b. ADDRESS: Montpelier Idaho
23c. DATE SIGNED: Oct 6, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mansfield Cemetery
24d. LOCATION (City, town, or county) (State): Mansfield Washington

DATE REC'D BY LOCAL REG.: 10/6/69
REGISTRAR'S SIGNATURE: Ruby Gortcinsky
25. EMBALMER: Nile Matthews
LICENSE NO.: E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 13 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4562
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED
OCT 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Mabel	Maryann	Thomas	Oct. 6. 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Jan. 23, 1890	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife 01		Ben. Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William J. Kuney	Switzerland	Anna Schmid	Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-26-3404	Cecil Thomas	Montpelier Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial infarction	15 min
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerosis	
DUE TO (c)	Hypertension	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
453	Montpelier, Idaho	Oct 9, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 10, 1969	Montpelier Cemetery	Montpelier Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13, 1969	Ruby Gotcinsky	Nile Matthews	E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 3 0 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4563
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED
OCT 14 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dingle
c. LENGTH OF STAY IN (this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home 001

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dingle
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Alfred	Dayton	Oakey	Oct.	7	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	July 11, 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming-Bookkeeping
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): Dingle, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Hyrum Oakey — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Selena Dayton — BIRTHPLACE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 529-22-9154
17. INFORMANT'S OWN SIGNATURE: ADDRESS: Dingle, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* None, 19__, *and that death occurred at* 2:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Mont Idaho
23c. DATE SIGNED: 10/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 11, 1969
24c. NAME OF CEMETERY OR CREMATORY: Dingle Cemetery
24d. LOCATION (City, town, or county) (State): Dingle Idaho

DATE REC'D BY LOCAL REG.: 10/13/69
REGISTRAR'S SIGNATURE: Ruby Gotcinsky
25. EMBALMER: Nile Matthews
LICENSE NO.: E359
FIRM NAME: Matthews Mortua ry

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4564
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Charles Idaho
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Charles, Idaho 040
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Cornell
b. (Middle) Stafford
c. (Last) Cleveland

4. DATE OF DEATH (Month) (Day) (Year) Oct 12 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH March 18, 1906
9. AGE (In years last birthday) 63
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Charles Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Stafford C. Cleveland
BIRTHPLACE St Charles
14. MOTHER'S MAIDEN NAME Hannah Sorenson
BIRTHPLACE St. Charles Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 528-16-9639
17. INFORMANT'S OWN SIGNATURE Max Cleveland
ADDRESS 3384 E. 67th St. Long Beach Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3032

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chrrosis, Alcoholic — 4-5 month
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/7, 1969, *to* 10/12, 1969, *that I last saw the deceased alive on* 10/12, 1969, *and that death occurred at* 6:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Jonathan H. Davies 675 (Degree or title) MD.
23b. ADDRESS Moat Id
23c. DATE SIGNED 10/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 15 1969
24c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery
24d. LOCATION (City, town, or county) (State) St. Charles Idaho.

DATE REC'D BY LOCAL REG. 10/13/69
REGISTRAR'S SIGNATURE Ruby Gortcinsky
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4565
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hosp. 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Wyoming 51
b. COUNTY: Teton 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jackson
d. STREET ADDRESS (If rural, give location): 222 Kelly st.

3. NAME OF DECEASED (Type or Print): a. (First) Bessie; b. (Middle) Woodward; c. (Last) Yale

4. DATE OF DEATH: (Month) Oct. (Day) 15, (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: June 5, 1902

9. AGE (In years last birthday): 67
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Idaho City, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. Woodward
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Kate Staley
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 520-14-8511

17. INFORMANT'S OWN SIGNATURE: Viola Mildred Irving
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH: 3 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11 Oct, 19 69, *to* 15 Oct, 19 69, *that I last saw the deceased alive on* 15 Oct, 19 69, *and that death occurred at* 2:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. Seth Dr MD
23b. ADDRESS: Montpelier Idaho
23c. DATE SIGNED: 10/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Oct. 16, 1969
24c. NAME OF CEMETERY OR CREMATORY: Jackson Cemetery
24d. LOCATION (City, town, or county) (State): Jackson Wyoming

DATE REC'D BY LOCAL REG.: 10/18/69
REGISTRAR'S SIGNATURE: Ruby Gorteinsky

25. EMBALMER: Nile Matthews
LICENSE NO.: E359
FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 29 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4566
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paris
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 001

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paris
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	Fredrick	Gaebel	Oct. 25. 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Male	White	Married	May 6 1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Of
11. BIRTHPLACE (State or foreign country): Paris. Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fredrick M. J. Gaebel	Germany	Elizabeth Ruppel	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes World War X
16. SOCIAL SECURITY NO.: 518-42-9986
17. INFORMANT'S OWN SIGNATURE: Paul Gaebel — ADDRESS: Denver. Colo.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Suicide — Cut Wrists — INTERVAL BETWEEN ONSET AND DEATH: [redacted]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): With Razer blade Wasn't found until Next Morning out in his
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. barn.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 04
21c. (CITY, TOWN, OR TOWNSHIP) Paris (COUNTY) Bear Lake (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Nile Matthews 583 Coroner	Montpelier Idaho	Oct 30'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 29. 1969	Paris Cemetery	Paris Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Ruby Gortcinsky	Nile Matthews	E359

FIRM NAME: Matthews Mortuary.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4567
Local Reg. No. 46
Reg. Dist. No. 130

Certificate of Death

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Community Hospital 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah 050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): General Delivery

3. NAME OF DECEASED (Type or Print)
a. (First): Fred
b. (Middle): none
c. (Last): Miller

4. DATE OF DEATH (Month) (Day) (Year): October 4, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: April 11, 1886
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Woodswork
10b. KIND OF BUSINESS OR INDUSTRY: 17 Logging
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Not Available — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Not Available — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-05-5200
17. INFORMANT'S OWN SIGNATURE: Guy F. Lowry — ADDRESS: St. Maries, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-3, 1969, *to* 10-4, 1969, *that I last saw the deceased alive on* 10-4, 1969, *and that death occurred at* 8:35 pm *from the causes and on the date stated above.*

23a. SIGNATURE: B. A. Rapp 428 — (Degree or title): M.D
23b. ADDRESS: St Maries, Idaho
23c. DATE SIGNED: 10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): St. Maries, Idaho

DATE REC'D BY LOCAL REG.: Oct. 21, 1969
REGISTRAR'S SIGNATURE: Donna Brown
25. EMBALMER: Gerald E. Browning
LICENSE NO.: E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4568
Local Reg. No. 47
Reg. Dist. No. 130

BIRTH NO.

NOV 10 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Community Hospital 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah 050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) Valley Vista Convalescent Cent.

3. NAME OF DECEASED (Type or Print) a. (First) HART b. (Middle) LEE c. (Last) BEBEE

4. DATE OF DEATH (Month) (Day) (Year) October 21, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH March 20, 1887

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith 21

10b. KIND OF BUSINESS OR INDUSTRY General

11. BIRTHPLACE (State or foreign country) Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Horace R. Bebee
BIRTHPLACE N.Y.

14. MOTHER'S MAIDEN NAME Orphenia Wilson
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-14-4245

17. INFORMANT'S OWN SIGNATURE Horace R Bebee
ADDRESS 801 [illegible], St. Maries

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C V A — INTERVAL BETWEEN ONSET AND DEATH 1 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — Unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4369

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* 21 Oct, 1969, *that I last saw the deceased alive on* 21 Oct, 1969 *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE W. D. Thurston, MD 533 (Degree or title)

23b. ADDRESS St. Maries Idaho

23c. DATE SIGNED 24 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 25, 1969

24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery

24d. LOCATION (City, town, or county) St. Maries (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 4, 1969

REGISTRAR'S SIGNATURE Donna Brown

25. EMBALMER Derald Browning
LICENSE NO. E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4569
Local Reg. No. 49
Reg. Dist. No. 130

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 18 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah (SD)
b. CITY OR TOWN Fernwood
LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) None 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Onaway
d. STREET ADDRESS (If rural, give location) 1/2 mile North of Potlatch

3. NAME OF DECEASED (Type or Print): a. (First) MARIE b. (Middle) JOSEPHINE c. (Last) CHILIMPIS

4. DATE OF DEATH (Month) (Day) (Year): October 26, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: January 1, 1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Henry McEvers — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary Anne Frazier — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-4999 B
17. INFORMANT'S OWN SIGNATURE: Dorothy L. McCall — ADDRESS: Fernwood, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10m

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* POA, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. D. Thurston (Degree or title) MD
23b. ADDRESS: St Maries Idaho
23c. DATE SIGNED: 13 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-30-69
24c. NAME OF CEMETERY OR CREMATORY: Freeze Cemetery
24d. LOCATION (City, town, or county) (State): Latah County, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17, 1969
REGISTRAR'S SIGNATURE: Donna Brown
25. EMBALMER: E. A. Ellsbury
LICENSE NO.: 1280

FIRM NAME: Kimball Funeral Home, Palouse, Wa. 99161

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4570
Local Reg. No. 48
Reg. Dist. No. 130

RECEIVED NOV 12 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Benewah 052
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
LENGTH OF STAY (in this place): 20 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah 052
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): Route #2

3. NAME OF DECEASED (Type or Print): a. (First) Ellsworth b. (Middle) Vivian c. (Last) Pryne

4. DATE OF DEATH (Month) (Day) (Year): October 31, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: June 18, 1906

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Woodswork

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Pryne
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Alvena Granli Pryne
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-14-7577

17. INFORMANT'S OWN SIGNATURE: Dorothy Olson
ADDRESS: Rt. 2, St. Maries

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 16 Sept 69

19b. MAJOR FINDINGS OF OPERATION: ventricular aneurysm, Coronary artery Thrombosis

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 17 Apr, 1953, *to* 31 Oct, 1969, *that I last saw the deceased alive on* 31 Oct, 1969, *and that death occurred at* 9 m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. L. Sullivan MD (Degree or title)

23b. ADDRESS: St. Maries

23c. DATE SIGNED: 3 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 3, 1969

24c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: Nov. 7, 1969

REGISTRAR'S SIGNATURE: Donna Brown

25. EMBALMER: Gerald Browning
LICENSE NO.: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16, inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4571
Local Reg. No. 146
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bingham (061) — NOV 14 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 1 yr 1mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville (101)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 400 E. 19th Street

3. NAME OF DECEASED (Type or Print): a. (First) LUCY; b. (Middle) J.; c. (Last) EDWARDS

4. DATE OF DEATH (Month) (Day) (Year): August 28 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 18 Sept. 1880

9. AGE (In years last birthday): 88
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 28

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lois Jones ?
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Pinkney ?
BIRTHPLACE: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519 60 6452T

17. INFORMANT'S OWN SIGNATURE: Mary Payne — ADDRESS: Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

485X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 21 Aug., 1969, *to* 28 Aug., 1969, *that I last saw the deceased alive on* 28 Aug., 1969, *and that death occurred at* 6:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD 594
23b. ADDRESS: State Hospital South-Blackfoot, Idaho
23c. DATE SIGNED: 4 Sep. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: SEP 9 1969
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Ira A. Williams — LICENSE NO.: E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4572
Local Reg. No. 147
Reg. Dist. No. 600

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061 NOV 14 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) Box 254

3. NAME OF DECEASED (Type or Print) a. (First) EVLYN b. (Middle) J. c. (Last) MONCUR

4. DATE OF DEATH (Month) (Day) (Year) August 29 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 29 June 1902

9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Wilson — BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Georgia Griffin — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mary Coyne ADDRESS Med. Records-State Hospital South

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure secondary to Hyperpyrexia. — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 22 Aug., *19* 69 *to* 29 Aug., *19* 69 *that I last saw the deceased alive on* 29 Aug., *19* 69 *and that death occurred at* 10:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD 594

23b. ADDRESS State Hospital South-Blackfoot, Idaho

23c. DATE SIGNED 4 Sep. 69

24a. BURIAL, CREMATION, REMOVAL (Specify) removal

24b. DATE 8/30/69

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert, Idaho

DATE REC'D BY LOCAL REG. SEP 9 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Howard Packham — LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form PH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 1 4 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4573
Local Reg. No. 148
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
d. STREET ADDRESS (If rural, give location): Riverton Road

3. NAME OF DECEASED (Type or Print): a. (First) Sherman b. (Middle) c. (Last) George

4. DATE OF DEATH: (Month) Sept. (Day) 3, (Year) 1969

5. SEX: male

6. COLOR OR RACE: Am. Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: June 1906

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer & Stockman 04

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Ft. Hall, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: General George — BIRTHPLACE: Ft. Hall, Idaho

14. MOTHER'S MAIDEN NAME: Ruth Jackson — BIRTHPLACE: Ft. Hall, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-38-6522

17. INFORMANT'S SIGNATURE AND RELATIONSHIP: Clara P. George — ADDRESS: Blackfoot, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Liver disease, probably malignancy — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

1978

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 29 July, 1969, to 3 Sept, 1969, *that I last saw the deceased alive on* 2 Sept., 1969, *and that death occurred at* 12:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Walter D Hoge 23+ (Degree or title): M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 9-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-6-69

24c. NAME OF CEMETERY OR CREMATORY: Gibson Cemetery

24d. LOCATION (City, town, or county) (State): Gibson, Bingham, Idaho

DATE REC'D BY LOCAL REG.: SEP 9 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Howard Packham — LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 4574
Local Reg. No. 138
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061 — OCT 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memeorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): Route 3 -- Box 107

3. NAME OF DECEASED (Type or Print): a. (First) DEMCY b. (Middle) C. c. (Last) STRUNK

4. DATE OF DEATH: (Month) October (Day) 1 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: September 12, 1879

9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate Agent 2Y

10b. KIND OF BUSINESS OR INDUSTRY: Self-employed

11. BIRTHPLACE (State or foreign country): Mountain Grove, Missouri

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME — BIRTHPLACE: Demcy W. Strunk

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Ann (no data)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 519-38-3978

17. INFORMANT'S OWN SIGNATURE — ADDRESS: (s) Mrs. Clarence Bray Blackfoot, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Vascular accident	3 dy
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Congestive heart failure	2 mo.
DUE TO (c)	Urinary Obstruction	6-8 days

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

4220

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 19 69, *to* Oct. 1, 19 69, *that I last saw the deceased alive on* Oct. 1, 1969, *and that death occurred at* 11:00 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Garden
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: OCT 20 1969
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: [signature]
LICENSE NO.: E - 349
FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4575
Local Reg. No. 129
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY in this place 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 029 Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 247 Shirley St.

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) I. c. (Last) STONE

4. DATE OF DEATH (Month) (Day) (Year) October 3, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH September 11, 1883

9. AGE (In years last birthday) 86
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 07

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) West Bend, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ira Dexter Stone
BIRTHPLACE New York

14. MOTHER'S MAIDEN NAME Isabella McCormick
BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-07-9302

17. INFORMANT'S OWN SIGNATURE Gladys Kirwan
ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) RENAL ARTERIOLOSCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH 2 YEARS

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 10 YEARS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* Oct 3, 19 69, *that I last saw the deceased alive on* Oct 3, 19 69, *and that death occurred at* 1:25a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Harry K. Haddock (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED Oct 6, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE October 6, 1969

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) Blackfoot (State) Idaho

DATE REC'D BY LOCAL REG. OCT 9 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER E. Dean Hill

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4576
Local Reg. No. 135
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 14 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 13yr9mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BOLIVAR	B.	BUCHANAN	October 5 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Aug. 1 1908	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Bolivar Buchanan — BIRTHPLACE Virginia
14. MOTHER'S MAIDEN NAME Frances B. Moffett — BIRTHPLACE Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 524 22 0883A
17. INFORMANT'S OWN SIGNATURE Mary Payne ADDRESS Med. Records-State Hospital South

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congestive Heart Failure	24 hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pleural Effusion	2 days
DUE TO (c)	Respiratory Failure	24 hrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

5112

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19 Sept., *19* 69, *to* 5 Oct., *19*69, *that I last saw the deceased alive on* 5 Oct., *19*69, *and that death occurred at* 1:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	m.d.	State Hospital South - Blackfoot, Idaho	6 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-10-69	State Hosp. So Cem.	Blackfoot, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 13 1969	Dorothy J. Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 4577
Local Reg. No. 738
Reg. Dist. No. 601

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Bingham 060 OCT 1 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural Groveland)
c. LENGTH OF STAY (In this place) 57 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. # 5

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13 b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural Groveland)
d. STREET ADDRESS (If rural, give location) Rt. # 5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PETER	Rasmus	Madsen	Oct. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 22, 1878	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming (Retired)	Agriculture	Granite, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mads Madsen	Denmark	Karen Olsen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-40-3098 A	Martha Madsen	Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4409 Generalized Arteriosclerosis — | INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1967 *to* October 5, 1969 *that I last saw the deceased alive on* Oct. 5, 1969 *and that death occurred at* 7:50p. m. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. M. Withers 569	M. D.	Blackfoot, Idaho	Oct. 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 8, 1969	Groveland Cemetery	Bingham County, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 9 1969	Dorothy J Jones	John C. Sandberg	E 280

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

BIRTH NO. 69-8963

RECEIVED OCT 13 1969 Bureau of Vital

State File No. 4578
Local Reg. No. 131
Reg. Dist. No. 601

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley, Rural
d. STREET ADDRESS (If rural, give location): R#1

3. NAME OF DECEASED (Type or Print)
a. (First): Floyd
b. (Middle): Thomas
c. (Last): DeMaree

4. DATE OF DEATH: (Month) Oct (Day) 6 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Babe

8. DATE OF BIRTH: Sept 1 1969

9. AGE (In years last birthday): IF UNDER 1 YR. Months Days 36; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 0

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Thomas DeMaree
BIRTHPLACE: Calif

14. MOTHER'S MAIDEN NAME: Adriann Marchi
BIRTHPLACE: Calif.,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Thomas L. DeMaree
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 911X Choked to death — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): aspiration of vomitus into
DUE TO (c): his lungs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): /

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 00

21c. (CITY, TOWN, OR TOWNSHIP) 13000 Shelley (COUNTY) Bingham (STATE) Idaho

21d. TIME OF INJURY (Month) 10 (Day) 06 (Year) 69 (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 1 19 69 *to* Oct 6 19 69 *, that I last saw the deceased alive on* _____ *, 19____, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Carl Staby 583 4 (Degree or title): Coron
23b. ADDRESS: 321 E. Walker Blackfoot
23c. DATE SIGNED: 10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-8-69
24c. NAME OF CEMETERY OR CREMATORY: Hill Crest
24d. LOCATION (City, town, or county): Shelley, Bingham (State): Idaho

DATE REC'D BY LOCAL REG.: OCT 8 1969
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Floyd M. Walker
LICENSE NO: E275-
FIRM NAME: Walker's Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4579
Local Reg. No. 139
Reg. Dist. No. 601

RECEIVED
OCT 23 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write township): Blackfoot (Rural Rockford)
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Road 20 miles west 060

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Arizona 03
b. COUNTY: 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chinle
d. STREET ADDRESS (If rural, give location): Indian Reservation

3. NAME OF DECEASED (Type or Print) a. (First): Guy b. (Middle): c. (Last): Tsosie
4. DATE OF DEATH: October 6, 1969
5. SEX: Male
6. COLOR OR RACE: Am. Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Aug. 3, 1945
9. AGE (In years last birthday): 24
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 64
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Not given
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Not given BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Not given BIRTHPLACE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Obtained from records ADDRESS: D. Jones

18. CAUSE OF DEATH — MEDICAL CERTIFICATION
Enter only one cause per line for (a), (b) and (c)
8147
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Broken Neck — INTERVAL BETWEEN ONSET AND DEATH: Instant
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Run over by a truck
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Farm Road 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 13060 (STATE): Blackfoot (20 miles west) Bimgham, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 6, 1969 1:00 A.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Run over by truck

22. I hereby certify that I attended the deceased from ____ 19__ to ____ 19__ that I last saw the deceased alive on Oct. 6, 19 69 and that death occurred at 1:00A. m., from the causes and on the date stated above.

23a. SIGNATURE: Carl Staley 583 (Degree or title): Coroner, Bingham County,
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Oct. 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
24b. DATE: Oct. 11, 1969
24c. NAME OF CEMETERY OR CREMATORY: Community Cemetery
24d. LOCATION (City, town, or county) (State): Chinle, Arizona

DATE REC'D BY LOCAL REG.: OCT 16 1969
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: John C. Sandberg
LICENSE NO.: E 280
FIRM NAME: Sandberg Hill Funeral Home Blackfoot, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4580
Local Reg. No. 137
Reg. Dist. No. 600

BIRTH NO.

RECEIVED OCT 13 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 1yr11day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Twin Falls 42
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 325 - 8th Avenue East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LOUIS	WILLIAM	BENKULA	October 7 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	7 January 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stone-Work 11	Construction	Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Benkula	Kansas	Lottie Eulert	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	527 07 9579A	Mary Payne	Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* 9 Sept., 1969, *to* 7 Oct., 1969, *that I last saw the deceased alive on* 7 Oct., 1969, *and that death occurred at* 10:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leon R. Marlowe 594 M.D.	State Hospital South-Blackfoot, Idaho	9 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-10-69	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 9 1969	Dorothy J. Jones	John C. Sandley	E-280

FIRM NAME: Twin Falls Mortuary - Twin Falls

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 19 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4581
Local Reg. No. 133
Reg. Dist. No. 600

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Sterling
d. STREET ADDRESS (If rural, give location) Sterling

3. NAME OF DECEASED (Type or Print): a. (First) David b. (Middle) Edwin c. (Last) Nelson

4. DATE OF DEATH: (Month) Oct. (Day) 7, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept. 26, 1891

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Own Ranch

11. BIRTHPLACE (State or foreign country): Heber City, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew David Nelson — BIRTHPLACE: Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME: Jane Elizabeth Sessions — BIRTHPLACE: Heber City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-42-7721

17. INFORMANT'S OWN SIGNATURE: Annie R. Nelson — ADDRESS: Sterling, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9288 Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Shock + Blood Clot to heart
DUE TO (c) tractor accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 04

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 20 miles W. Blackfoot 13060 Bingham Idaho

21d. TIME OF INJURY (Month) 10 (Day) 7 (Year) 69 (Hour) 4:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 7, 19 69 *to* _____, 19___, *that I last saw the deceased alive on* Oct 7, 19 69, *and that death occurred at* 6 P.M. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl Stoney 583 Coroner

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 10- 9- 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-10-69

24c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery

24d. LOCATION (City, town, or county) (State): Springfield, Bingham, Idaho

DATE REC'D BY LOCAL REG. OCT 10 1969

REGISTRAR'S SIGNATURE: Dorothy J Jones

25. EMBALMER: Howard Packham

LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1969

MAR 18 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4582
Local Reg. No. 136
Reg. Dist. No. 600

BIRTH REC'D OCT 14 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bureau of Vital Statistics Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 061
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 490 East Idaho

3. NAME OF DECEASED (Type or Print): a. (First) Elda; b. (Middle); c. (Last) Jolley

4. DATE OF DEATH: (Month) Oct. (Day) 8, (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Nov. 17, 1918

9. AGE (In years last birthday): 50
IF UNDER 1 YEAR: Months 11 Days 9
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY: Home and School

11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leo M. Woodland
BIRTHPLACE: Marsh Center, Idaho

14. MOTHER'S MAIDEN NAME: Florence Rollison
BIRTHPLACE: Louisa County, Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 572-22-6250

17. INFORMANT'S OWN SIGNATURE: Kenneth D. Jolley
ADDRESS: Blackfoot, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: Weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetic glomerulonephrosis — Years
DUE TO (c) Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pituitary tumor, anemia, goiter

2509

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-29, 1969, *to* 10-8, 1969, *that I last saw the deceased alive on* 10-8, 1969, *and that death occurred at* 10:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 361 (Degree or title) M.D.

23b. ADDRESS: 9 Airport Rd. Blackfoot, Idaho

23c. DATE SIGNED: 10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-11-69

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.: OCT 13 1969

REGISTRAR'S SIGNATURE: D. X. James

25. EMBALMER: Howard Packham
LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4583
Local Reg. No. 134
Reg. Dist. No. 600

BIRTH NO.

RECEIVED OCT 13 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 007
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 007
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 143 Alder Street

3. NAME OF DECEASED (Type or Print): a. (First) Raymond; b. (Middle); c. (Last) McClellan

4. DATE OF DEATH (Month) (Day) (Year): Oct. 8, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 2, 1886

9. AGE (In years on last birthday): 83
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance (Retired) 54

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Swan Lake, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Washington McClellan — BIRTHPLACE: Eccelshill, England

14. MOTHER'S MAIDEN NAME: Sarah Quigley — BIRTHPLACE: Clarkston, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-07-8008 A

17. INFORMANT'S OWN SIGNATURE: Dorthe McClellan — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 2509 Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 1
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Deabetes mellitus — 10 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 8, 1957 to Oct. 8, 69, that I last saw the deceased alive on Oct. 8, 1969, and that death occurred at 5:36 p.m., from the causes and on the date stated above.

23a. SIGNATURE: Leigh M. Coates 183 (Degree or title) M. D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Oct. 9, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 11, 1969

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: OCT 10 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: John C. Sandberg — LICENSE NO.: E 280

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4584
Local Reg. No. 140
Reg. Dist. No. 600

BIRTH NO.

RECEIVED Bureau of Vital Statistics OCT 23 1969

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot,
c. LENGTH OF STAY (In this place): 2 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley, 212
d. STREET ADDRESS (If rural, give location): 212 No. Byron

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Ida	May	Whitmill	Oct.	8	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Sept 7, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Rigby, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard D. Prophet	Centerville, Utah	Edith Saxton	Hull, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-09-8249 A	Rhea Nelson	Basalt, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

398X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Rheumatic & Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus. — 3 years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 1961, *to* 8 Oct, 1969, *that I last saw the deceased alive on* 8 Oct, 1969, *and that death occurred at* 3:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Walter W Hoge 234	MD	Blackfoot, Idaho	OCT 13 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 10, 1969	Basalt, Idaho	Shelley, R#1 Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 16 1969	Dorothy J. Jones	Lloyd M. Nalder	E 275

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Nalder Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
OCT 14 1969
BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 4585
Local Reg. No. 137
Reg. Dist. No. 601

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH — Bureau of Vital Statistics
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Grandview
c. LENGTH OF STAY (in this place): 1½ hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Potato Cellar - Grandview

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Sterling
d. STREET ADDRESS (If rural, give location): Sterling

3. NAME OF DECEASED (Type or Print): a. (First) Terrel b. (Middle) R. c. (Last) Anderson

4. DATE OF DEATH: (Month) (Day) (Year): October 10, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: March 21, 1957

9. AGE (In years last birthday): 12
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: Jr. High School

11. BIRTHPLACE (State or foreign country): American Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Von T. Anderson
BIRTHPLACE: Springfield, Idaho

14. MOTHER'S MAIDEN NAME: Ramona Pierce
BIRTHPLACE: Aberdeen, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Von T. Anderson
ADDRESS: Sterling

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9288

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Severe Brain damage — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Crushed skull
DUE TO (c): Tractor Accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 04
21c. (CITY, TOWN, OR TOWNSHIP) 13060 (COUNTY) (STATE): Grandview Bingham Idaho
21d. TIME OF INJURY: (Month) 10 (Day) 10 (Year) 69 (Hour) 9:30 a.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see him alive, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 9:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Carl Staley 583
(Degree or title): Coroner
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: 10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-13-69
24c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery
24d. LOCATION (City, town, or county) (State): Springfield, Bingham, Idaho

DATE REC'D BY LOCAL REG.: OCT 13 1969
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Howard Packham
LICENSE NO.: E-338

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Howard Packham Mortuary

DUTIES:

OCT 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4586
Local Reg. No. 141
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061 OCT 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY IN (this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) OSCAR c. (Last) CHAFFIN

4. DATE OF DEATH: (Month) October (Day) 10, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: February 28, 1896

9. AGE (In years last birthday): 73

IF UNDER 1 YR. Months / Days

IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Livestock

10b. KIND OF BUSINESS OR INDUSTRY: Ranch

11. BIRTHPLACE (State or foreign country): Circleville, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Chaffin
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Sarah Louise Collins
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-22-0783

17. INFORMANT'S OWN SIGNATURE: Mrs Irene Chaffin ADDRESS: Blackfoot, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ventricular tachycardia — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial infarction — 5 days
DUE TO (c) Arteriosclerotic heart disease — yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. emphysema, ventricular aneurysm

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 30 January, 1967 to Oct 10, 1969, that I last saw the deceased alive on October 10, 1969, and that death occurred at 6:22p.m., from the causes and on the date stated above.

23a. SIGNATURE: A E Miller Jr. (Degree or title) M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Oct 14, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Oct 14, 1969

24c. NAME OF CEMETERY OR CREMATORY: Groveland Cemetery

24d. LOCATION (City, town, or county) (State): Bingham county, Idaho

DATE REC'D BY LOCAL REG.: OCT 20 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: John C. Sandberg

LICENSE NO.: E-280

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 31 1969

NOV 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
NOV 4 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4587
Local Reg. No. 729
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 429

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 061
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): Main Street Apt's.

3. NAME OF DECEASED (Type or Print): a. (First) Velva b. (Middle) Maria c. (Last) Weiser

4. DATE OF DEATH: (Month) Oct. (Day) 17, (Year) 1969

5. SEX: female

6. COLOR OR RACE: Am. Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Mar. 12, 1939

9. AGE (In years last birthday): 30
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer & housewife

10b. KIND OF BUSINESS OR INDUSTRY: Potato cellars

11. BIRTHPLACE (State or foreign country): Ft. Washakie, Wyoming

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Tarness BIRTHPLACE: Ft. Washakie, Wyoming

14. MOTHER'S MAIDEN NAME: Nettie Timbana BIRTHPLACE: Ft. Washakie, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 9887

17. INFORMANT'S OWN SIGNATURE: * Mrs Dona I. Weiser ADDRESS: Ft. Washakie, Wyoming

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Injury abdomen - Rupt. Liver & gall Bladder — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic alcoholism

19a. DATE OF OPERATION: 16 Oct 69

19b. MAJOR FINDINGS OF OPERATION: Peritonitis, Necrotic wedge of Liver, Torn gall bladder, Severe Shock

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): unknown

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Coroner Checking it out.

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1960, 19__, to 17 Oct, 1969, that I last saw the deceased alive on 17 Oct, 1969, and that death occurred at 10:30 P m., from the causes and on the date stated above.

23a. SIGNATURE: O. Dean Packer 403 (Degree or title): M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 10-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-23-69

24c. NAME OF CEMETERY OR CREMATORY: Sacajawea Cemetery

24d. LOCATION (City, town, or county) (State): Ft. Washakie, Fremont, Wyo.

DATE REC'D BY LOCAL REG.: Oct. 23, 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Howard Packham

LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 3 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4588
Local Reg. No. 149
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot,
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blackfoot Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley,
d. STREET ADDRESS (If rural, give location) 355 So. Holms

3. NAME OF DECEASED (Type or Print) a. (First) Lorenzo b. (Middle) c. (Last) Balmforth

4. DATE OF DEATH (Month) Oct (Day) 20 (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 5 May 1886

9. AGE (In years last birthday) 83

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Balmforth BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Hannah Hepworth BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-14-1728

17. INFORMANT'S OWN SIGNATURE Dorothy D. Fielding ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

402X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH 5yr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic hypertensive heart disease 15yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Urinary obstruction - Prostatism 98hr.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 1950, to Oct 20, 1969, that I last saw the deceased alive on Oct. 20, 1969, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE 404 (Degree or title) M D

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED 10-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-24-69

24c. NAME OF CEMETERY OR CREMATORY Hill Crest

24d. LOCATION (City, town, or county) Shelley, Bingham (State) Idaho

DATE REC'D BY LOCAL REG. 7 Nov. 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Floyd M Nalder

LICENSE NO. E 275

FIRM NAME: Nalder's Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Vital Statistics Bureau

State File No. 4589
Local Reg. No. 143
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 06 Bingham NOV 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
LENGTH OF STAY (In this place) 6 yr. 4 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Cone Street 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 36 Cone Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ivan		Orgill	October 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Jan. 22, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Automotive	McCammon, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Edward Orgill	Hyrum, Utah	Estella Hall	Portage, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-28-9624	Mrs. Ivan Orgill	Blf't.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) VENTRICULAR FIBRILLATION — INTERVAL BETWEEN ONSET AND DEATH: 5-10 Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) MYOCARDIAL INFARCTION — 5-10 Minutes
DUE TO (c) CORONARY ARTERIOSCLEROSIS — 5 YEARS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 7:30 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harry K. Haddock	M.D.	Blackfoot, Idaho	10-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-23-69	Grove City Cemetery	Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 23 1969	Dorothy J. Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4590
Local Reg. No. 144
Reg. Dist. No. 600

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot,
c. LENGTH OF STAY (In this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blackfoot Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley,
d. STREET ADDRESS (If rural, give location): 170 E. Locust

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) c. (Last) Chantrill

4. DATE OF DEATH: (Month) Oct (Day) 21 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2 July 1882

9. AGE (In years last birthday): 87
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Implement Dealer
10b. KIND OF BUSINESS OR INDUSTRY: Farm Machinery

11. BIRTHPLACE (State or foreign country): College Ward, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Chantril BIRTHPLACE: SingleBorough, England

14. MOTHER'S MAIDEN NAME: Annis Adeline Preston BIRTHPLACE: Bedford, Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 528-09-5138

17. INFORMANT'S OWN SIGNATURE: Susan E. Chantrill ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* Oct. 21, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: O.M. Withers 569 (Degree or title) M.D.

23b. ADDRESS: Blackfoot Idaho.

23c. DATE SIGNED: 10/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-25-69

24c. NAME OF CEMETERY OR CREMATORY: Hill Crest

24d. LOCATION (City, town, or county) (State): Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG.: 27 Oct. 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Gary L. Nielsen

LICENSE NO.: E444

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4591
Local Reg. No. 145
Reg. Dist. No. 600

RECEIVED NOV 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bingham 061	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot c. LENGTH OF STAY (In this place): 9 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 860 West Sexton 000	d. STREET ADDRESS (If rural, give location): 860 West Sexton

3. NAME OF DECEASED (Type or Print)	a. (First): Pleasant (Pez)	b. (Middle): Warren	c. (Last): DaBell	4. DATE OF DEATH (Month) (Day) (Year): October 26 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Dec. 16, 1879	9. AGE (In years last birthday): 89 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Harrisville, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Alfred K. DaBell	BIRTHPLACE: England	14. MOTHER'S MAIDEN NAME: Julia Ann Taylor	BIRTHPLACE: Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519 38 6400	17. INFORMANT'S OWN SIGNATURE: Wayne DaBell	ADDRESS: Mooreland, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5699

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Not Known

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 58, *to* 10-26, 19 69, *that I last saw the deceased alive on* 10-22, 19 69, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Sumpacher M.D. 404 (Degree or title)	23b. ADDRESS: Blackfoot, Idaho	23c. DATE SIGNED: 10/29/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10/29/69	24c. NAME OF CEMETERY OR CREMATORY: Central Cemetery	24d. LOCATION (City, town, or county) (State): Grant Jefferson County Idaho
DATE REC'D BY LOCAL REG.: OCT 31 1969	REGISTRAR'S SIGNATURE: Dorothy J. Jones	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
BIRTH NOV 1 4 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4592
Local Reg. No. 151
Reg. Dist. No. 600

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Blackfoot
d. STREET ADDRESS (If rural, give location) Ft. Hall Reservation Bannock Rodd - So. of Blackfoot

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) c. (Last) Boise, Sr.
4. DATE OF DEATH (Month) Oct. (Day) 31, (Year) 1969
5. SEX male
6. COLOR OR RACE Am. Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Mar. 15, 1898
9. AGE (In years last birthday) 71 IF UNDER 1 YR. Months 7 Days 16 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and Stockman 04
10b. KIND OF BUSINESS OR INDUSTRY Own Ranch
11. BIRTHPLACE (State or foreign country) Ft. Hall, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nate Boise BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Annie Pokibro BIRTHPLACE Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-24-9789
17. INFORMANT'S OWN SIGNATURE X Ida Z. Boise ADDRESS Ft. Hall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-31, 1969, to 10-31, 1969, *that I last saw the deceased alive on* 10-31, 1969, *and that death occurred at* 9:35 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE J. M. Sellers 569 (Degree or title) M.D.
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED 11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-4-69
24c. NAME OF CEMETERY OR CREMATORY Gibson Cemetery
24d. LOCATION (City, town, or county) (State) Ft. Hall Res., Bingham, Idaho

DATE REC'D BY LOCAL REG. 6 Nov. 1969
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER Howard Packham
LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4593
Local Reg. No. 35
Reg. Dist. No. 410

Certificate of Death

RECEIVED OCT 27 1969 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Sun Valley Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Star Rt. Hailey, Idaho
d. STREET ADDRESS (If rural, give location): Triunph, Star Route

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ERNEST		HAAR	October 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Oct. 26, 1914	54	11	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
cattle 04	buying	Bowdle, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Haar	unk	Pauline Aldinger	unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		504-42-2392	Hulda Haar	Hailey, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction, presumed — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* didn't see alive, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	752 MD	Sun Valley, Idaho	10/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	10/8/69	Hailey Cemetery	Hailey, Idaho

DATE REC'D BY LOCAL REGR.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 23 69	Robert H. Wright	Keith Bird	E-373

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev. Rev. 8-W

FIRM NAME: Bird Funeral Home

FEB 18 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4594
Local Reg. No. 36
Reg. Dist. No. 410

RECEIVED
OCT 27 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bellevue
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ARTHUR
b. (Middle): WILLIAM
c. (Last): KNOEPFEL

4. DATE OF DEATH (Month) (Day) (Year): Oct. 12, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 10, 1948
9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrican Helper
10b. KIND OF BUSINESS OR INDUSTRY: 07 mine
11. BIRTHPLACE (State or foreign country): Scotts Bluff, Neb.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Arthur W. Knoepfel — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Margaretia Fleenor — BIRTHPLACE: unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-58-3081
17. INFORMANT'S OWN SIGNATURE: + Mrs. Janet Knoepfel — ADDRESS: Bellevue, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4210

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10-12-69

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Fungal endocarditis — 4-69
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1966, *to* 10-12, 1969, *that I last saw the deceased alive on* 10/12, 1969, *and that death occurred at* 1 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 752
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 10/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/15/69
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: Oct 22/69
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird — Keith Bird
LICENSE NO.: E-373

Federal Security Agency
United States Public Health Service

Form DH-63021 per CBW

FIRM NAME: Bird Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 12 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 20 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4595
Local Reg. No. 352
Reg. Dist. No.

BIRTH NO.

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Boise 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gardner Mountain
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gardner Mountain Boise County 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: BOise 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): on Moores Creek 24 Miles north of Boise
d. STREET ADDRESS (If rural, give location): Moores Creek

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Orville	Reed	Myers	10- 4- 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married	10-1-1910	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Forest Service Scaler 17	Saw Mill	Boise, Idaho	U.S.A..

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George S. Myers	OKlahoma	Maysie N. Reed	Clearfield Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	518-28-5457	Mrs. Mildred Myers	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4299

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
App. Heart Attact		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Never *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 4 Boise Co. Coronor	Star Rt. Banks Idaho	10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-7-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11/1/69	Henriette Perrault	Eric B. Byram	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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State File No. 4596
Local Reg. No. #100
Reg. Dist. No.

RECEIVED NOV 6 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 526 S. Marion

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Forest
c. (Last): Brennan

4. DATE OF DEATH (Month) (Day) (Year): Sept. 30, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 20, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Ranch
11. BIRTHPLACE (State or foreign country): Dakota Territory
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Brennan — BIRTHPLACE: No record
14. MOTHER'S MAIDEN NAME: Millie Ann Hosmer — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 501 09 6839A
17. INFORMANT'S OWN SIGNATURE: X Myrtle Churchill — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arterio sclerosis — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1962, *to* 9-30, 1969, *that I last saw the deceased alive on* 9-29, 1969, *and that death occurred at* 4:20 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. Manenau -327 MD
23b. ADDRESS: Sandpoint Ida
23c. DATE SIGNED: 10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
24d. LOCATION (City, town, or county) (State): Priest River Idaho

DATE REC'D BY LOCAL REG.: 11/4/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 1 5 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4597
Local Reg. No. #97
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 09
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 330 Euclid

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Clara		Holz	Oct. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 22, 1877	92				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
No record	no record	No record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 50 5086	Mrs. Laura L Purdy	Montpelier

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerbrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardio-vascular disease and hypertension — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 16, 19 55, *to* Oct. 3, 19 69, *that I last saw the deceased alive on* Sept. 28, 19 69, *and that death occurred at* 6:15 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Peterson MD 415	Sandpoint, Idaho	10/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 4, 1969	Pinecrest Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10/14/69	Dale Pederson	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4598
Local Reg. No. #95
Reg. Dist. No.

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 4 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Margaret b. (Middle) Agnes c. (Last) Bacon

4. DATE OF DEATH (Month) (Day) (Year): October 4, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 14, 1879
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Mathern — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Mary Brecht — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 481 22 7064
17. INFORMANT'S OWN SIGNATURE: Mrs. Kenneth Hunnicutt — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral vascular accident — 1 day
DUE TO (c) Atherosclerotic vascular disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 2, 1957, *to* Oct 4, 1969, *that I last saw the deceased alive on* Oct 4, 1969, *and that death occurred at* 8:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 471 (Degree or title) MD
23b. ADDRESS: [signature] Idaho
23c. DATE SIGNED: 10/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
24d. LOCATION (City, town, or county) (State): Toledo, Iowa

DATE REC'D BY LOCAL REG.: 10/14/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — Moon Funeral Service
LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4599
Local Reg. No. #39
Reg. Dist. No.

BIRTH NO.

OCT 24 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonners 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Athol
d. STREET ADDRESS (If rural, give location): Athol, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) ANNIE; b. (Middle) L.; c. (Last) PUCKETT

4. DATE OF DEATH: (Month) Oct. (Day) 10, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 9/4/1876

9. AGE (In years last birthday): 93
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: UNKNOWN
BIRTHPLACE: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN
BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-60-9897

17. INFORMANT'S OWN SIGNATURE: Robert Puckett
ADDRESS: Athol, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4048

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiovascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 7, 1969, *to* Oct 10, 1969, *that I last saw the deceased alive on* Oct 9, 1969, *and that death occurred at* 6A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Munson (Degree or title): MD

23b. ADDRESS: Sandpoint Ida

23c. DATE SIGNED: 10-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/14/69

24c. NAME OF CEMETERY OR CREMATORY: Athol Cemetery

24d. LOCATION (City, town, or county) (State): Athol, Idaho

DATE REC'D BY LOCAL REG.: 10/23/69

REGISTRAR'S SIGNATURE: Kate Pederson

25. EMBALMER: Fred Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

APR 2 7 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4600
Local Reg. No. #40
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH 091 OCT 24 1969
a. COUNTY: Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 939

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hope
d. STREET ADDRESS (If rural, give location): Lake Aire Motel

Bureau of Vital St

3. NAME OF DECEASED (Type or Print): a. (First) Elmer; b. (Middle) Aldine; c. (Last) Atherton

4. DATE OF DEATH (Month) (Day) (Year): October 12, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Apr 14, 1913

9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chart man 19

10b. KIND OF BUSINESS OR INDUSTRY: Gasoline company

11. BIRTHPLACE (State or foreign country): U.S.A.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elmer Atherton
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Myrtle Bell Morris
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 714 16 0313

17. INFORMANT'S OWN SIGNATURE: ✓ Viola M Atherton
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5718

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PORTAL CIRRHOSIS & LIVER FAILURE + RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: ESSENTIAL HYPERTENSION & PULMONARY EMPHYSEMA
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): None

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-9 *19*69, *to* 10-12, *19*69, *that I last saw the deceased alive on* 10-12, *19*69, *and that death occurred at* 9 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: Theodore E. Ahn (Degree or title) MD

23b. ADDRESS: 321 N 2nd Ave SANDPOINT IDAHO

23c. DATE SIGNED: 10-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

24b. DATE: Oct 16, 1969

24c. NAME OF CEMETERY OR CREMATORY: Long Beach Cemetery

24d. LOCATION (City, town, or county) (State): Long Beach California

DATE REC'D BY LOCAL REG.: 10/21/69

REGISTRAR'S SIGNATURE: Nola Pederson

25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4601
Local Reg. No. #98
Reg. Dist. No.

BIRTH NO.

OCT 24 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 041
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 4 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 034

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Route 2 - West Pine

3. NAME OF DECEASED (Type or Print): a. (First) Lucy b. (Middle) Emma c. (Last) Caroline Bidwell

4. DATE OF DEATH (Month) (Day) (Year): October 17, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 20, 1898

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry C. Kautz
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Anna M. Cook
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 518 24 1006B

17. INFORMANT'S OWN SIGNATURE: * W L Bidwell
ADDRESS

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/17, 1969, to 10/17, 1969, that I last saw the deceased alive on 10/17, 1969, and that death occurred at 12 50 pm., from the causes and on the date stated above.

23a. SIGNATURE: James R. Cathcart (Degree or title) MD

23b. ADDRESS: 502 N. 2nd. Ave.

23c. DATE SIGNED: 10/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct 21, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Memorial Park

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 10/23/69

REGISTRAR'S SIGNATURE: Hale Anderson

25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 27 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4602
Local Reg. No. 347
Reg. Dist. No. 610

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN: L.D.S. Hospital: IF, I
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 861 North Skyline

3. NAME OF DECEASED (Type or Print)
a. (First): KATHRYN
b. (Middle): ALICE
c. (Last): JOHNS

4. DATE OF DEATH (Month) (Day) (Year): Sept 25, 1969

5. SEX: Femael

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 24, 1893

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Eaton, Colorado

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Amicus N. Miller
BIRTHPLACE: Georgia

14. MOTHER'S MAIDEN NAME: Arietta Nix
BIRTHPLACE: Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 38 6718 D

17. INFORMANT'S OWN SIGNATURE: Mrs. Marilyn Grund
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Cerebral Arteriosclerosis

DUE TO (c): & Arteriosclerotic Heart Disease with Auricular Fibrillation — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 6, 1961, *to* Sept. 25, 1969, *that I last saw the deceased alive on* Sept. 25, 1969, *and that death occurred at* 4:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 104 (Degree or title)
23b. ADDRESS: 798 South Boulevard, Idaho Falls, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9 29 69
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 21-1969
REGISTRAR'S SIGNATURE: Emma Budge
25. EMBALMER: [signature]
LICENSE NO.: E 387
FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

BARNARD

Certificate of Death

STATE OF IDAHO

State File No. 4603
Local Reg. No. 337
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Utah 45
b. COUNTY 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salt Lake City
d. STREET ADDRESS (If rural, give location) 1159 Concord Street

3. NAME OF DECEASED (Type or Print) a. (First) Lisa b. (Middle) Gay c. (Last) Aubrey

4. DATE OF DEATH (Month) (Day) (Year) October 4, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Jan 13, 1969

9. AGE (In years last birthday) IF UNDER 1 YR. Months 8 Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 021

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alan D. Aubrey BIRTHPLACE Salt Lake City, Ut.

14. MOTHER'S MAIDEN NAME Susan Gay Baumgartner BIRTHPLACE ~~Salt Lake City~~ U.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE By telephone ADDRESS

18. CAUSE OF DEATH 8199
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) auto accident with subdural hematoma — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10-3-69

19b. MAJOR FINDINGS OF OPERATION subdural hematomas

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 06

21c. (CITY, TOWN, OR TOWNSHIP) 27655 (COUNTY) (STATE) Montana

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10 - 3 - 69 m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR? auto accident

22. I hereby certify that I attended the deceased from 10-3-69, 19____, to 10-4-69, 19____, that I last saw the deceased alive on 10-3-69, 19____, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE George Barnard MD 021 (Degree or title)

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED 10-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem & Bur 3

24b. DATE Oct 8, 1969

24c. NAME OF CEMETERY OR CREMATORY Salt Lake City Cem.

24d. LOCATION (City, town, or county) (State) Salt Lake City, Utah

DATE REC'D BY LOCAL REG. Oct. 15. 69

REGISTRAR'S SIGNATURE Anna Budge

25. EMBALMER Daniel A. Hansen

LICENSE NO. E-510

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4604
Local Reg. No. 334
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
c. LENGTH OF STAY:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO 13
b. COUNTY: BONNEVILLE 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): 1346 N. Fremont Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SAMUEL	GEORGE	KING	Oct 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Setp 2,1895	74	1 / 3	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waiter 06	cafe	Shelley, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George King	England	Emily Barnes	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Disc from Draft War 1 3		Minnie King	City

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Healed Pulmonary Tuberculosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Pulmonary Emphysema

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from January, 1968, to Oct 5, 1969, that I last saw the deceased alive on Oct 5, 1969, and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron Weeks MD	1585 South Boulevard	10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 9, 1969	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 17-1969	Anna Rudgier	Leo A Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG 10 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4605
Local Reg. No. 339
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 1/2 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 158 West Short St.

3. NAME OF DECEASED (Type or Print)
a. (First) FRANCILDA
b. (Middle) ISABELLA
c. (Last) BOULTER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 3, 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Draper, Utah.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Newbold — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Isabella Harwood — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-14-0295
17. INFORMANT'S OWN SIGNATURE: Lillian Bowcutt — ADDRESS: Rt. #2 Rigby, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 12 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: no operations
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/8, 1946, *to* Oct 7, 1969, *that I last saw the deceased alive on* Oct 6, 1969, *and that death occurred at* 9:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Aldon Lall — (Degree or title): M.D.
23b. ADDRESS: Rigby, Idaho.
23c. DATE SIGNED: 10/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Oct. 10, 1969
24c. NAME OF CEMETERY OR CREMATORY: Little Butte
24d. LOCATION (City, town, or county) (State): Annis, Jefferson Idaho.

DATE REC'D BY LOCAL REG.: Oct 15-69
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: APR 1 1 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4606
Local Reg. No. 340
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 21 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1554 W. Broadway

3. NAME OF DECEASED (Type or Print): a. (First) DAVID b. (Middle) c. (Last) KLINGENBERG

4. DATE OF DEATH (Month) (Day) (Year): Oct 8, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: April 8, 1915

9. AGE (In years last birthday): 54
IF UNDER 1 YR. Months: 6 Days: 0
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager 26

10b. KIND OF BUSINESS OR INDUSTRY: Mel Brown Pump Co.

11. BIRTHPLACE (State or foreign country): Bakersfield, Cal.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: August C. Klingenberg
BIRTHPLACE: Woodson, Kansas

14. MOTHER'S MAIDEN NAME: Elsie Myrtle Booth
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Harvey A. Klingenberg
ADDRESS: City

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial infarction with ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* October 8, 19 69, *to* , 19 , *that I last saw the deceased alive on* October 8, 19 69, *and that death occurred at* 7:40P m., *from the causes and on the date stated above.*

23a. SIGNATURE 208 Harvey A. Hatch (Degree or title) MD

23b. ADDRESS: 1050 Memorial Dr. Idaho Falls Idaho

23c. DATE SIGNED: 10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct 13, 1969

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct 17 1969

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Leo A. Williams

LICENSE NO.: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4607
Local Reg. No. 333
Reg. Dist. No. 6/D

BIRTH NO.

RECEIVED
OCT 14 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route # 5 Box 339

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Lawford	Meikle	October 8 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 25, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Ogden, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert W. Meikle	Utah	Sarah Ann Summers	So. Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 14 3930	Lorine Meikle	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cancer of Lung C — INTERVAL BETWEEN ONSET AND DEATH: 3 Months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): metastases to cervical
DUE TO (c): Lymph nodes

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Metastatic Bronchogenic Carcinoma in Supra clavicular Lymph Nodes	Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* Oct 8, 1969, *that I last saw the deceased alive on* Oct. 8, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harvey G. Hatch M.D	Idaho Falls Idaho	Oct. 9, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/11/69	Pioneer Cemetery	Rigby Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 11- 69	Emma Bridges	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH–63021

NOV 4 1969
NOV 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Void

Certificate of Death

STATE OF IDAHO

State File No. 4608
Local Reg. No. 342
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 28 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE (10)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. HOSPITAL 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO b. COUNTY: BONNEVILLE (10)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): 1273 Boise, Ave. Idaho Falls

3. NAME OF DECEASED (Type or Print): a. (First) JACOB b. (Middle) CHRISTIAN c. (Last) KRAFT

4. DATE OF DEATH: (Month) (Day) (Year): Oct 11, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 31, 1906

9. AGE (In years last birthday): 63 IF UNDER 1 YR. Months: 2 Days: 10 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Claryville, Kentucky

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Christian Kraft BIRTHPLACE: Cincinnati, Ohio

14. MOTHER'S MAIDEN NAME: Emma Vilena Brickler BIRTHPLACE: Claryville, Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 548-01-6317

17. INFORMANT'S OWN SIGNATURE: Mary Crompton ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis — Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-11, 1969, to 10-11, 1969, *that I last saw the deceased alive on* 10-11, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 54b (Degree or title)

23b. ADDRESS: Idaho Falls, Ida

23c. DATE SIGNED: 10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct 15, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 23-1969

REGISTRAR'S SIGNATURE: Anne Bridges

25. EMBALMER: Leo A Williams

LICENSE NO.: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969
JAN 5 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 12 1969 Bureau of Vital Statistics

State File No. 4609
Local Reg. No. 351
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location) 549 North Water Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) AMY	b. (Middle) *	c. (Last) MILLER	4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1969
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 25, 1895	9. AGE (In years last birthday) 74 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Tripp, South Dakota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David H. Rands	BIRTHPLACE Canada	14. MOTHER'S MAIDEN NAME Sarah Arnsberger	BIRTHPLACE Nebraska	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518 54 2020	17. INFORMANT'S OWN SIGNATURE Mrs Jim Paschke	ADDRESS IF, I	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) A.S.H.D. — —

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 2, 1951, *to* October 11, 1969, *that I last saw the deceased alive on* October 11, 1969, *and that death occurred at* 5:20 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE 244 L. K. Krantz (Degree or title) L. K. Krantz, M.D.	23b. ADDRESS 798 South Boulevard Idaho Falls, Idaho	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE Oct. 15, 69	24c. NAME OF CEMETERY OR CREMATORY Pioneer Cemetery	24d. LOCATION (City, town, or county) (State) Rigby, Idaho
DATE REC'D BY LOCAL REG. Nov. 4-'69	REGISTRAR'S SIGNATURE Anna Bridger	25. EMBALMER Buck Sullivan	LICENSE NO. E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 4610
Local Reg. No. 343
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville (01) OCT 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 490 10th St. (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 490 10th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	FREDERICK	WILSON	October 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 3, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Station Operator	Petroleum	Columbia, Pennsylvania	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Wilson	P.A.	Helen Welsh,	P.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 14 4160	Mrs Wm F Wilson	Idaho Falls Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 6 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Mar - 1964, 19___, to Oct - 12, 1969, that I last saw the deceased alive on Oct - 11, 1969, and that death occurred at ___m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. C. Erickson M.D.	Idaho Falls, Idaho	10-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 15, 69	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 23-69	Anna Bridges	Buck Sullivan	E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4611
Local Reg. No. 347
Reg. Dist. No. 670

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Rest Home (348)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1063 Irving St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thomas	James	Ward	Oct. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct. 4, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Drover (27)	General	Ogden Valley, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Ward	Utah	Kate Brown	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 20 8770	Nora Lona Ward	Ucon Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) + Chronic fibrosis
DUE TO (c) of lung

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Chronic pulmonary fibrosis - emphysema	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John S Hall (210) MD	Idaho Falls, Idaho 1050 Memorial Dr.	10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal (3)	Oct. 17, 69	Pioneer Cemetery	Rigby, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30-1969	Anna Rudger	Bill Sullivan	E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

State File No. 4612
Local Reg. No. 344
Reg. Dist. No. 6 16

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 20 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route # 1 Box 269

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lorna		Robinson	October 15 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Sept. 18, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher 12	School	Milleville, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Yeates	USA	Elizabeth Bailey	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 24 1081A	Geo La Robinson	Route # 1 I.F.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4330

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 4 years
DUE TO (c) Hypertensive Vascular Disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes Mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10-18, 1966, to 10-15, 1969, that I last saw the deceased alive on 10-15, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	54b	Idaho Falls, Ida	10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/18/69	Ucon Cemetery	Ucon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 25-1969	Anna Bridges	Ralph M. Wood [signature]	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

State File No. 4613
Local Reg. No. 360
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bonneville	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls MONTHS OF STAY (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 415 May	d. STREET ADDRESS (If rural, give location): 415 May

3. NAME OF DECEASED (Type or Print)	a. (First): Jack	b. (Middle):	c. (Last): Cunningham	4. DATE OF DEATH (Month) (Day) (Year): October 16 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: March 29, 1921	9. AGE (In years last birthday): 48 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: U & I Sugar Co.	11. BIRTHPLACE (State or foreign country): Linkol, Wyoming	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Cunningham	BIRTHPLACE: Penn.	14. MOTHER'S MAIDEN NAME: Ann Quinn	BIRTHPLACE: Scotland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes, give war or dates of service): WW 11	16. SOCIAL SECURITY NO.: 520 14 9191	17. INFORMANT'S OWN SIGNATURE: Frank Cunningham	ADDRESS

4299

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) Idaho Falls (COUNTY) Bonne- (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Vernal Bydalek (Degree or title): 583 4 Coroner	23b. ADDRESS: 38 Q 4 E. 17th	23c. DATE SIGNED: 11-6-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10/21/69	24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	24d. LOCATION (City, town, or county): Idaho Falls (State): Idaho
DATE REC'D BY LOCAL REG.: Nov. 10-1969	REGISTRAR'S SIGNATURE: Anna Budger	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4614
Local Reg. No. 352
Reg. Dist. No. 616

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 12 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (At this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 644 North Water Ave.

3. NAME OF DECEASED (Type or Print): a. (First) HJALMAR b. (Middle) * c. (Last) HOLM

4. DATE OF DEATH (Month) (Day) (Year): Oct. 17, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 11, 1880

9. AGE (In years last birthday): 89
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer, retired 07

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Skenninge, Sweden

12. CITIZEN OF WHAT COUNTRY?: Nat.

13. FATHER'S NAME: Axel Holm
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Caroline Anderson
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Yes

INFORMANT'S OWN SIGNATURE: George H. Holm
ADDRESS: Ida. Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 887X Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fractured Hip — 2 wks
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE: XX (Specify): 1

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Home 01

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls Ida 13.01

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 3,69 6a m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Fell at home

22. *I hereby certify that I attended the deceased from* 1960 *to* 1969 *that I last saw the deceased alive on* Oct 17 1969 *and that death occurred at* 2 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. H. Harrison MD

23b. ADDRESS: Idaho Falls Ida

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 20, 69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: NW.4-1969

REGISTRAR'S SIGNATURE: Anna Budge

25. EMBALMER: R. E. Sullivan

LICENSE NO.: E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4615
Local Reg. No. 345
Reg. Dist. No. 610

BIRTH NO.

OCT 28 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 483 West 16th Street	d. STREET ADDRESS (If rural, give location): 483 West 16th Street

3. NAME OF DECEASED (Type or Print)	a. (First): George	b. (Middle): Richardson	c. (Last): Stewart	4. DATE OF DEATH (Month) (Day) (Year): October 18 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced	8. DATE OF BIRTH: March 28, 1906	9. AGE (In years last birthday): 63 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: Roger Bros. Seed Co.	11. BIRTHPLACE (State or foreign country): Winther, Colorado	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: NOT AVAILABLE	BIRTHPLACE	14. MOTHER'S MAIDEN NAME: NOT AVAILABLE	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518 05 9246	17. INFORMANT'S OWN SIGNATURE: Georgia Hanson	ADDRESS: Idaho Falls, Ida	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction	Acute
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 6-28-60, 19___, *to* 10-18, 19 69, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 546 (Degree or title)	23b. ADDRESS: Idaho Falls, Ida	23c. DATE SIGNED: 10-22-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10/22/69	24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	24d. LOCATION (City, town, or county): Idaho Falls (State): Idaho
DATE REC'D BY LOCAL REG.: Oct. 25-1969	REGISTRAR'S SIGNATURE: Anna Bridges	25. EMBALMER: Ralph M. Wood [signature]	LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED NOV 4 1969 Bureau of Vital Statistics

State File No. 4616
Local Reg. No. 348
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley,
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Hazel b. (Middle) Agusta c. (Last) Harker

4. DATE OF DEATH (Month) Oct (Day) 19 (Year) 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 12 Aug. 1885
9. AGE (In years last birthday) 84 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Werner Lawson BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Carolena Dahlquist BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-4269 T
17. INFORMANT'S OWN SIGNATURE Norman Harker ADDRESS

4339

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15, 1969, *to* Oct 19, 1969, *that I last saw the deceased alive on* Oct 19, 1969, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23a. SIGNATURE 556 Byron T Weeks M D (Degree or title)
23b. ADDRESS 1585 So. Boulevard Idaho Falls
23c. DATE SIGNED 10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 23-'69
24c. NAME OF CEMETERY OR CREMATORY Hillcrest
24d. LOCATION (City, town, or county) Shelley, Bingham (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 30-1969
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER L.M. Nalder Lloyd M Nalder
LICENSE NO. E-275

FIRM NAME: Nalder's Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4617
Local Reg. No. 346
Reg. Dist. No. 610

RECEIVED
Bureau of Vital Statistics
OCT 28 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville (01)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1010 Rose Avenue

3. NAME OF DECEASED (Type or Print): a. (First) EUNICE b. (Middle) ISABELLE c. (Last) TAYLOR

4. DATE OF DEATH: (Month) (Day) (Year) October 19, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 1, 1886

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): St. Johns, Arizona.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Anders Jensen
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Josephine Hales
BIRTHPLACE: Spanish Fork, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-40-8286D

17. INFORMANT'S OWN SIGNATURE: Blanche D. Whitehead
ADDRESS: 1010 Rose Ave. Idaho Falls, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial failure due — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive heart disease, characterized by auricular fibrillation. — 8 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Arteriosclerosis, obliterative, posterior tibial artery, left leg. — 3 days

402X

19a. DATE OF OPERATION: 10-17-69

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3-9, 1966, *to* 10-19, 1969, *that I last saw the deceased alive on* 10-19, 1969, *and that death occurred at* 6:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Idaho Falls, Idaho.

23c. DATE SIGNED: 10-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 23, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rigby Pioneer

24d. LOCATION (City, town, or county) (State): Rigby Jefferson Idaho

DATE REC'D BY LOCAL REG.: Oct. 25. 69

REGISTRAR'S SIGNATURE:

25. EMBALMER: Bruce A. Eckersell
LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4618
Local Reg. No. 361
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 262 North Ridge Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 311 North Ridge Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Philip	S.	Keefer	October	20	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	January 29, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Custodian 06	Custodial	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Walker Keefer	Pennsylvania	Dora Virginia Shoemaker	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1	519 22 8008	Fred W Keefer	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		Idaho Falls	Bonne.	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Verna Bydalek	Deputy Coroner	3884 E. 17th	11-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	10/24/69	Rose Hill Cemetery	Idaho Falls	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 10 1969	Anna Bridges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

State File No. 4619
Local Reg. No. 55-8
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Idaho Falls L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
d. STREET ADDRESS (If rural, give location): Rt. #5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Annie	Pearl	Murdock	Oct.	22,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	white	married	April 22, 1891	78	6			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Dallas, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Orlando Jones	Willard, Utah	Nellie Sandberg	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-40-9520	x D L Murdock	Rt.5, Blackfoot

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 8199 Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe CVS injury — 2 days.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
19 Oct 69	Cerebral contusion	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	C6	20000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Oct 19 '69 6 p.m.		auto accident

22. *I hereby certify that I attended the deceased from* 10 - 19, 19 69, *to* 10 - 22, 19 69, *that I last saw the deceased alive on* 10-22, 19 69 *and that death occurred at* 7:30 PM, *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	230 M.D.	Idaho Falls, Idaho	10-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 18	10-25-69	Riverside-Thomas Cem.	Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 1-1969	Anna Bridges	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV . 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4620
Local Reg. No. 363
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L. D. S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Cash County Ut
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hyde Park
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Alice	Ashcroft	Duce		Oct	25	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Nov 6 1884	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Hyde Park Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Franklin Ashcroft,	Hyde Park Utah	Sarah Elizabeth Hawkes,	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		528-50-5329	Franklin A. Duce	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Intertrochanteric fracture, right	2 mos.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. — DUE TO (b)	hip	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic arteriosclerotic heart disease	15 yrs.

887X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Idaho Falls, Idaho (Bonneville)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		Fall athome

22. *I hereby certify that I attended the deceased from* 8-21, 19 69 *to* 10-26-, 19 69, *that I last saw the deceased alive on* 10-26, 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. J. Bingham	MD	Idaho Falls, Idaho Oct. 25, 1969	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Removal 3	10-25-69	Hyde Park	Hyde Park, Cash	Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 12-1969	Anna Bridges	Lloyd M. Nalder	E 273

FIRM NAME: Nalder's Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

BIRTH NO. 69-10104

RECEIVED NOV 12 1969 Bureau of Vital Statistics

State File No. 4621
Local Reg. No. 354
Reg. Dist. No. 610

1. PLACE OF DEATH a. COUNTY Bonneville	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho 13 b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042	d. STREET ADDRESS (If rural, give location) 181½ 8th

3. NAME OF DECEASED (Type or Print) a. (First) Scot	b. (Middle) Blair	c. (Last) Hanson	4. DATE OF DEATH (Month) (Day) (Year) Oct 25, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Baby	8. DATE OF BIRTH Oct 24 1969	9. AGE (In years last birthday) IF UNDER 1 YR. Months Days 1 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Idaho Fall, Idaho	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gerald Lin Hanson	BIRTHPLACE Idaho Falls, Idaho	14. MOTHER'S MAIDEN NAME Lorna Wadsworth	BIRTHPLACE Idaho Falls, Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Gerald Lin Hanson	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7761

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Respiratory distress syndrome	1 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hyaline membrane disease	
DUE TO (c)	Prematurity	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 24 Oct, 1969, *to* 25 Oct, 1969, *that I last saw the deceased alive on* 25 Oct, 1969, *and that death occurred at* 11:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE R. K. Leibelt, M.D. 304 (Degree or title)	23b. ADDRESS 9th & Offord, Idaho Falls, Ida	23c. DATE SIGNED 4 Nov. 69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10.27.69	24c. NAME OF CEMETERY OR CREMATORY Hill Crest
24d. LOCATION (City, town, or county) Shelley, Bingham (State) Idaho		
DATE REC'D BY LOCAL REG. Nov. 8-1969	REGISTRAR'S SIGNATURE Anna Bredger	25. EMBALMER Gary L. Naeder
LICENSE NO. E444		

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4622
Local Reg. No. 349
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sugar City
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MINNIE	MORTIMER	LUSK	October 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	July 12, 1903	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hibbard, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Mortimer — BIRTHPLACE: Logan, Utah
14. MOTHER'S MAIDEN NAME: Edith Ricks — BIRTHPLACE: Cache Junction, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 519-42-9289
17. INFORMANT'S OWN SIGNATURE: Dale Lusk — ADDRESS: Taber, Alta. Canada

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes mellitus. — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Secondary anemia unknown cause — 3 months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Thyroglossal duct cyst.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-20, 1969, *to* 10-25, 1969, *that I last saw the deceased alive on* 10-25, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 10/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/29/69	Fielding Memorial	Idaho Falls, Bonneville Idaho

DATE REC'D BY LOCAL REG.: Oct. 31-69
REGISTRAR'S SIGNATURE: Anna Rudge
25. EMBALMER: Kenneth R. Flamm — LICENSE NO.: E347
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63621

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 10 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4623
Local Reg. No. 353
Reg. Dist. No. 610

BIRTH NO.

NOV 20 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN THIS PLACE: 10 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Nursing Home 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE; b. (Middle) IRA; c. (Last) WHEELER

4. DATE OF DEATH: (Month) October (Day) 25, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: August 27, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months 2 Days 28
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Potato

11. BIRTHPLACE (State or foreign country): American Falls

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ezra L. Wheeler
BIRTHPLACE: Eden, Utah

14. MOTHER'S MAIDEN NAME: Levina Gardner
BIRTHPLACE: Minden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE: Lettie Mae Wheeler C.W.H.
ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart attack — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis — 6 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic encephalopathy 2° arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* October 25, 19 69, *that I last saw the deceased alive on* October 25, 19 69, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. Wm Bell (033) (Degree or title) M.D.

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: Oct 28, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Oct 28, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rockland cemetery

24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov 5 1969

REGISTRAR'S SIGNATURE: Emma Bridges

25. EMBALMER: E. Dean Hill

LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 1 1970

MAY 11 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 20 1969 Bureau of Vital Statistics

State File No. 4624
Local Reg. No. 363
Reg. Dist. No. 611

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Homer Creek inthe Caribou
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): National Forest 20 mi due So. of Bone

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Iona
d. STREET ADDRESS (If rural, give location): Box 314

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Donald	Edward	Janes	October	26	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	January 28, 1951	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	College	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Vern(Budd)Janes	Idaho	Golda Ethel Moss	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Not Available	Edward V Janes Jr	Iona, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9229

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gun shot wound — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident	East of Bone Idaho 31	Iona	Bonne 1310	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
oct	26	69	11:30 P.M.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____ *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Verna Bydalek Coroner	3824 E. 17th	11-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/29/69	Iona Cemetery	Iona Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10-1969	Anna Bridges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4625
Local Reg. No. 364
Reg. Dist. No. 6/6

BIRTH NO.

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1035 12th St.

3. NAME OF DECEASED (Type or Print) a. (First) Baby b. (Middle) c. (Last) Micek
4. DATE OF DEATH (Month) (Day) (Year) Oct. 26, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Oct. 26, 1969
9. AGE (In years last birthday) IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min. 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Idaho Falls Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BIRTHPLACE
14. MOTHER'S MAIDEN NAME Linda Micek BIRTHPLACE Powell, Wyo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Mary J. Micek ADDRESS Ida. Falls

18. CAUSE OF DEATH — MEDICAL CERTIFICATION
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 7472 Congenital Defect of great vessels of the arch, Pulmonary artery into aortic arch — INTERVAL BETWEEN ONSET AND DEATH 16 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Atelectasis, pulmonary — 16 hours

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/26, 1969, to 10/26, 1969, that I last saw the deceased alive on 10/26, 1969, and that death occurred at 5:05 p.m., from the causes and on the date stated above.

23a. SIGNATURE Hal N Davis MD 133 (Degree or title)
23b. ADDRESS 9th & Ogden Idaho Falls Idaho
23c. DATE SIGNED 11/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 28, 69
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) Idaho Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 7-1969
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER
LICENSE NO. E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

State File No. 4626
Local Reg. No. 355
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (If in this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LD.S. Hospital 043	d. STREET ADDRESS (If rural, give location) 375 K Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Aileen	Wheeler	Wolverton	October 28 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	May 29, 1892	77	4	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Josiah Stephen Wheeler	Huntsville, Utah	Hannah Jeanette Henderson	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None		J.W. Wolverton	Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral thrombosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 - 8 - , 1969, *to* 10 - 28 - , 1969, *that I last saw the deceased alive on* 9 - 24 - , 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
John S McMillan 348 MD (Degree or title)	550 Fourth St	11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	October 31, 1969	Robbin Cemetery	Robbin Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NW 5 1969	Anna Bridge	Leo A. Williams	E-319

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 3 0 1979
OCT 0 2 2014

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

State File No. 4627
Local Reg. No. 356
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bonneville 100	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ririe c. LENGTH OF STAY (In this place): Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ririe
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 430 1st South 000	d. STREET ADDRESS (If rural, give location): 430 1st South

3. NAME OF DECEASED (Type or Print) a. (First): Albert	b. (Middle):	c. (Last): Wheeler	4. DATE OF DEATH (Month) (Day) (Year): October 29 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: April 4, 1905	9. AGE (In years last birthday): 64 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24	10b. KIND OF BUSINESS OR INDUSTRY: Automotive	11. BIRTHPLACE (State or foreign country): Poplar, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Wheeler	BIRTHPLACE: Utah	14. MOTHER'S MAIDEN NAME: Mary M. Atkinson	BIRTHPLACE: Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519 09 2813	17. INFORMANT'S OWN SIGNATURE: Marcellene Wheeler	ADDRESS:	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cancer of lung with

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Brain metastasis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Cancer of lung

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1968, *to* Oct, 1969, *that I last saw the deceased alive on* 10-6, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: John Hatch MD 210 (Degree or title)	23b. ADDRESS: Idaho Falls Idaho	23c. DATE SIGNED: 11-3-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3	24b. DATE: 11/1/69	24c. NAME OF CEMETERY OR CREMATORY: Pioneer Cemetery	24d. LOCATION (City, town, or county): Rigby Jefferson Co. (State): Idaho
DATE REC'D BY LOCAL REG.: Nov 7-1969	REGISTRAR'S SIGNATURE: Anna Bridger	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

JUN 12 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

AUG 12 2010 -1

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4628
Local Reg. No. 387
Reg. Dist. No. 6 10

BIRTH NO.

RECEIVED NOV 12 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Bonneville	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IRwin
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital	d. STREET ADDRESS (If rural, give location): Box 86

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Annie	Myrtle	McDaniel	October 30 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	May 4, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Alpine, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Dunsdon	England	Ellen Wetham	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 24 1794	Alton McDaniel	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of lung with

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Urbral metastasis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-23-1959 *to* 10-30-1969 *that I last saw the deceased alive on* 9-27-1969 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John L. McMullin M.D.	550 Fourth St.	11-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/3/69	Fielding Memorial Park	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 7 1969	Anna Bridges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 3 0 2002

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4629
Local Reg. No. 930
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (In this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 932 East Elva

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 932 East Elva

3. NAME OF DECEASED (Type or Print): a. (First) Benjamin; b. (Middle) L.; c. (Last) Aerts

4. DATE OF DEATH: October 31 1969

5. SEX: Male

6. COLOR OR RACE: Navaho

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 3, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Roger Bros. Seed

11. BIRTHPLACE (State or foreign country): Cimmaron, New Mexico

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: NOT AVAILABLE
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: NOT AVAILABLE
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 711 18 1906

17. INFORMANT'S OWN SIGNATURE: x Mona L. Aerts
ADDRESS: Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-30, 19 68, *to* 10-31, 19 69, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE _____ (Degree or title)

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/4/69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 7 1969

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Ralph M. Wood Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 14 1969

NOV 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 6 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4630
Local Reg. No. 365
Reg. Dist. No. 670

BIRTH NO.

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. at L.D.S. Hospital (042)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 385 Lomax

3. NAME OF DECEASED (Type or Print) a. (First) Sarah b. (Middle) Christine c. (Last) Boyle

4. DATE OF DEATH (Month) (Day) (Year) October 31, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 17, 1898

9. AGE (In years last birthday) 71
IF UNDER 1 YR. Months 4 Days 24
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Teacher (12)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Lewisville, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Walter Selck

BIRTHPLACE

14. MOTHER'S MAIDEN NAME Sarah Elizabeth Myler

BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Seth Huffaker.
ADDRESS C.Ty -

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

8147

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiple trauma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) N. Holmes Ave. (04)

21c. (CITY, TOWN OR TOWNSHIP) Idaho Falls (COUNTY) Bonne. (13,01) (STATE) Idaho

21d. TIME OF INJURY (Month) oct (Day) 31 (Year) 69 (Hour) 6:09 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Car pedestrian accident

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Vernal Rydalch (583) (Degree or title) Coroner.

23b. ADDRESS 3804 E. 17th

23c. DATE SIGNED 11-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 4, 1969

24c. NAME OF CEMETERY OR CREMATORY Fielding Memorial Park

24d. LOCATION (City, town, or county) Idaho Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 13-1969

REGISTRAR'S SIGNATURE Emma Rudger

25. EMBALMER Leo A. Williams

LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 8 1970

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APR 2 0 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4631
Local Reg. No. 51-69
Reg. Dist. No. 100

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY IN THIS PLACE: 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): P. O. Box #182

3. NAME OF DECEASED (Type or Print): a. (First) MARIE b. (Middle) ELOISE c. (Last) BOWELL

4. DATE OF DEATH (Month) (Day) (Year): September 15, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 12, 1893

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Greencastle, Indiana

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Hiram Callender
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Nancy Glass
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 519-42-5308

17. INFORMANT'S OWN SIGNATURE: Official Records
ADDRESS

4360

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A.
INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Repeated Strokes 8 yrs. Bedfast 7 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* ____, 19 66, *to* 9/15, 19 69, *that I last saw the deceased alive on* 9/15, 19 69, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/18/69

24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery

24d. LOCATION (City, town, or county): Bonners Ferry (State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 6, 1969

REGISTRAR'S SIGNATURE

25. EMBALMER

LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4632
Local Reg. No. 47-69
Reg. Dist. No. 100

RECEIVED
Bureau of Vital Statistics
OCT 14 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boundary 10
b. CITY OR TOWN Bonners Ferry
LENGTH OF STAY (in this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5 mi East of Bonners Ferry on Highway #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Spokane 55
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 2404 Crown Avenue

3. NAME OF DECEASED (Type or Print) a. (First) LAVERNE b. (Middle) PERKINS c. (Last) FOWLER

4. DATE OF DEATH (Month) (Day) (Year) October 10, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 8, 1919
9. AGE (In years last birthday) 50
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY InterstateCommerce
11. BIRTHPLACE (State or foreign country) Palmer, Texas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Homer Fowler
BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Ola Perkins
BIRTHPLACE Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs. Laverne P. Fowler Spokane, Wn. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Skull Fracture — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Massive Fracture Left Temporal Bone — Minutes

DUE TO (c) Massive Trauma to head and face — Minutes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. S emi-trailer truck accident

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway #2
21c. (CITY, TOWN, OR TOWNSHIP) Bonners Ferry (COUNTY) Boundary (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10/10/69 2:30 A.M.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Semi-trailer left highway and rolled over

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, 19__, to _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE C. M. Callahan (Degree or title) Coroner
23b. ADDRESS Bonners Ferry, Idaho
23c. DATE SIGNED 10/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 10/10/69
24c. NAME OF CEMETERY OR CREMATORY Hazen & Jaeger Funeral Homes
24d. LOCATION (City, town, or county) Spokane (State) Washington

DATE REC'D BY LOCAL REG. Oct. 10, 1969
REGISTRAR'S SIGNATURE Loryla Stone
25. EMBALMER
LICENSE NO. E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 24 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 18 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4633
Local Reg. No. 4[illegible]-69
Reg. Dist. No. 100

Certificate of Death

RECEIVED
OCT 24 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 20 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Naples
d. STREET ADDRESS (If rural, give location): Star Route

3. NAME OF DECEASED (Type or Print)
a. (First): VIOLET
b. (Middle): (NONE)
c. (Last): ROBINSON

4. DATE OF DEATH (Month) (Day) (Year): October 17, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 7, 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaking
11. BIRTHPLACE (State or foreign country): Fort Collins, Colorado
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Eli Yockey — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Agnes Hooley — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 519-60-9898
17. INFORMANT'S OWN SIGNATURE: Eugene Robinson — ADDRESS: Naples, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5718

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): billiary cirhosis — est. 6+ mo
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Massive ascites — See Whs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: cirhosis, gall bladder disease
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1969, *to* Oct, 1969, *that I last saw the deceased alive on* 10/17, 1969, *and that death occurred at* A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): F. Quinn 103 MD
23b. ADDRESS: Bonners Ferry
23c. DATE SIGNED: 10/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/21/69
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry, Idaho

DATE REC'D BY LOCAL REG.: Oct. 22, 1969
REGISTRAR'S SIGNATURE: Troyla Stone
25. EMBALMER: [signature]
LICENSE NO.: E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

OCT 2 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 3 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
OCT 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4634
Local Reg. No. 4-69
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary (10)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 113 Chinook (00)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary (10)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): 113 Chinook

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) BRYANT c. (Last) WYATT

4. DATE OF DEATH (Month) (Day) (Year): October 20, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: October 24, 1905

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Grain Elevator

11. BIRTHPLACE (State or foreign country): Chillhowie, Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Charles H. Wyatt
BIRTHPLACE: Virginia

14. MOTHER'S MAIDEN NAME: Georgia Ann Perker
BIRTHPLACE: Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 519-03-7278

17. INFORMANT'S OWN SIGNATURE: Gertrude Wyatt
ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Ruptured esophageal Varices — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary — "
DUE TO (c): Congestive Heart failure — yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1963 *to* 10/20, 1969, *that I last saw the deceased alive on* 10/18, 1969, *and that death occurred at* 5:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 153 (Degree or title): MD
23b. ADDRESS: Bonners Ferry
23c. DATE SIGNED: 10/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/24/69
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: 10/26/69
REGISTRAR'S SIGNATURE: Virginia Stone
25. EMBALMER: [signature]
LICENSE NO.: E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4635
Local Reg. No. 5
Reg. Dist. No. 670

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
OCT 10 1969

1. PLACE OF DEATH
a. COUNTY 120 Butte
b. CITY OR TOWN Arco
c. LENGTH OF STAY IN (If outside corporate limits, write RURAL and give township) 10 mins
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Butte 120
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
d. STREET ADDRESS (If rural, give location) 604 DeCoria Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) ALVIN
b. (Middle) EDGAR
c. (Last) OWSLEY

4. DATE OF DEATH (Month) (Day) (Year) October 4, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH October 9, 1908

9. AGE (In years last birthday) 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Hagerman, Idaho

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Myron H. Owsley
BIRTHPLACE Corrinne, Utah

14. MOTHER'S MAIDEN NAME Viola Gridley
BIRTHPLACE Hagerman, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-09-9203

17. INFORMANT'S OWN SIGNATURE Norma L. Owsley
ADDRESS Arco,

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial infarct
INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1969, *to* Oct 4, 1969, *that I last saw the deceased alive on* Oct 4, 1969 *and that death occurred at* 11:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE C. Parker 031 (Degree or title)

23b. ADDRESS Arco, Ida

23c. DATE SIGNED 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-7-69

24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery

24d. LOCATION (City, town, or county) (State) Hagerman, Idaho

DATE REC'D BY LOCAL REG. Oct. 8-1969

REGISTRAR'S SIGNATURE Betty J. Marvel

25. EMBALMER C. O. Marvel
LICENSE NO. E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 24 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 4 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4636
Local Reg. No. 6
Reg. Dist. No. 670

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Butte 120 OCT 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
c. LENGTH OF STAY IN THIS PLACE: 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Custer 190
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Mackay
d. STREET ADDRESS (If rural, give location): Trail Creek Beus Ranch

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lost Rivers Hospital 264

3. NAME OF DECEASED (Type or Print): a. (First) CRIT b. (Middle) (JACK) c. (Last) HALL

4. DATE OF DEATH: (Month) Oct. (Day) 12, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 7, 1903

9. AGE (In years last birthday): 66
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shepherd 04

10b. KIND OF BUSINESS OR INDUSTRY: Sheep Raising

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willie Hall
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Minnie Hall
BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes 4
(If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 368-26-6512A

17. INFORMANT'S OWN SIGNATURE: Beulah Pence
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7960

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Peritonitis
INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ruptured Viscus.
INTERVAL BETWEEN ONSET AND DEATH: 3-6

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bowel Obstruction
INTERVAL BETWEEN ONSET AND DEATH: 2 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 12, 1969 to Oct 12, 1969, that I last saw the deceased alive on Oct 12, 1969, and that death occurred at 7:30p m., from the causes and on the date stated above.

23a. SIGNATURE: R Baker MD (Degree or title)

23b. ADDRESS: Arco, Ida

23c. DATE SIGNED: 10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 16-69

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: Oct. 22, 1969

REGISTRAR'S SIGNATURE: Betty J. Marvel

25. EMBALMER: C. H. Marvel

LICENSE NO.: E-457

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4637
Local Reg. No. 7
Reg. Dist. No. 670

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mackay
d. STREET ADDRESS (If rural, give location): 802 W. Custer

3. NAME OF DECEASED (Type or Print)
a. (First): CLYDE
b. (Middle): W.
c. (Last): BITTON

4. DATE OF DEATH (Month) (Day) (Year): October 18, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 24, 1913
9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician 68
10b. KIND OF BUSINESS OR INDUSTRY: Atomic Energy
11. BIRTHPLACE (State or foreign country): Riverside, Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Louis A. Bitton — BIRTHPLACE: Ogden, Utah
14. MOTHER'S MAIDEN NAME: Zina W. Bitton — BIRTHPLACE: Henefer, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. II 4
16. SOCIAL SECURITY NO.: 197-03-3687
17. INFORMANT'S OWN SIGNATURE: Doris M Bitton — ADDRESS: Mackay, Idaho

4319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 17, 1969, *to* Oct 18, 1969, *that I last saw the deceased alive on* Oct 18, 1969, *and that death occurred at* 11:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Barker (D.) 031
23b. ADDRESS: Arco, Ida
23c. DATE SIGNED: 10-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-21-69
24c. NAME OF CEMETERY OR CREMATORY: Mt. McCaleb
24d. LOCATION (City, town, or county) (State): Mackay, Idaho

DATE REC'D BY LOCAL REG.: Oct. 22-1969
REGISTRAR'S SIGNATURE: Betty J. Marvel
25. EMBALMER: E. Marvel
LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 1 8 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics
NOV 4 1969

State File No. 4638
Local Reg. No. 520
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park View Nursing Home 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilder
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Fred	Lee	Winter	Sept. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	January 7, 1875	94		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ø		Jacks Valley, Nevada	USA

13. FATHER'S NAME / BIRTHPLACE	14. MOTHER'S MAIDEN NAME / BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
No	None	X Grace L. Colley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO (b)~~ Benign Prostatic Hypertrophy
DUE TO (c) Chronic Infection — Days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 29, 1962 to Sept. 25, 1969, that I last saw the deceased alive on Sept 25, 1969, and that death occurred at 8 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Grayden Olsen MD	Nampa Idaho	10-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4639
Local Reg. No. 485
Reg. Dist. No. 360

RECEIVED OCT 13 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home- 516-6th. Ave. South 602

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 516-6 Ave. South

3. NAME OF DECEASED (Type or Print): a. (First) Stephen b. (Middle) Everett c. (Last) Bean, Sr.

4. DATE OF DEATH: (Month) October (Day) 1, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: January 5, 1891

9. AGE (In years last birthday): 78
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Owner-Oper. Sand & 22

10b. KIND OF BUSINESS OR INDUSTRY: Gravel Pit

11. BIRTHPLACE (State or foreign country): Swanton Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles O. Bean
BIRTHPLACE: Maine

14. MOTHER'S MAIDEN NAME: Annabelle Pilcher
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 520 09 7357

17. INFORMANT'S OWN SIGNATURE: I Catherine Bean
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4123

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8/1/ , 19 68 , *to* 10/1/ , 19 69 , *that I last saw the deceased alive on* 10/1/ , 19 69 , *and that death occurred at* 2:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert Elder (Degree or title) MD

23b. ADDRESS: 619 So. Canyon, Nampa, Idaho

23c. DATE SIGNED: 10/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 4, 1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county): Canyon County

(State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 9, 1969

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: Jerry D. Krouk

LICENSE NO.: E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4640
Local Reg. No. 481
Reg. Dist. No. 360

BIRTH NO.

OCT 9 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa	c. LENGTH OF STAY (If outside place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor 301		d. STREET ADDRESS (If rural, give location): 312-21 Ave. South

3. NAME OF DECEASED (Type or Print) a. (First): Walter	b. (Middle): Harrison	c. (Last): Carr	4. DATE OF DEATH (Month) (Day) (Year): October 1, 1969		
5. SEX: Male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: October 25, 1875	9. AGE (In years last birthday): 93	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grain Buyer 22	10b. KIND OF BUSINESS OR INDUSTRY: Grain	11. BIRTHPLACE (State or foreign country): Newcastle, Indiana	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Robert Bartlett	BIRTHPLACE: Kentucky	14. MOTHER'S MAIDEN NAME: Phoebe Smith	BIRTHPLACE: Indiana		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 503-01-5089	17. INFORMANT'S OWN SIGNATURE: X Helen J. Larsen	ADDRESS: Nampa, Ida.		

4339

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cerebral Vascular Disease — 1 yr

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 - 3, 1960, *to* 10 - 1, 1969, *that I last saw the deceased alive on* 9 - 24, 1969, *and that death occurred at* 1:05P m., *from the causes and on the date stated above.*

23a. SIGNATURE: 2+2 C Horton MD (Degree or title)	23b. ADDRESS: 1223-7 St. So., Nampa	23c. DATE SIGNED: 10-4-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct. 3, 1969	24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county): Nampa	(State): Idaho	
DATE REC'D BY LOCAL REG.: Oct. 8, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: Jerry J. Krouch
LICENSE NO.: E-447		

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4641
Local Reg. No. 507
Reg. Dist. No. 360

RECEIVED OCT 27 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp 35

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1204 ½ Dearborn Street

3. NAME OF DECEASED (Type or Print): a. (First) Jeannette b. (Middle) Katherine c. (Last) Casey

4. DATE OF DEATH (Month) (Day) (Year): Oct. 1, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 4, 1892

9. AGE (In years last birthday): 77 IF UNDER 1 YEAR Months: 5 Days: 27 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Mark BIRTHPLACE: Lithuania

14. MOTHER'S MAIDEN NAME: Anna Paulawskas BIRTHPLACE: Lithuania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 353-24-1935

17. INFORMANT'S OWN SIGNATURE: A. L. Mack ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

398X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Rheumatic Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES XX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-20-60, 19____, *to* 10-1-69, 19____, *that I last saw the deceased alive on* 10-1-69, 19____, *and that death occurred at* 10:10A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W Wyffels MD

23b. ADDRESS: 222 East Elm, Caldwell, Idaho

23c. DATE SIGNED: 10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 3, 1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 24, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Lucy M. Flaniff

LICENSE NO.: E-393

FIRM NAME: Flaniff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 2 2 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 22 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4642
Local Reg. No. 494
Reg. Dist. No. 360

BIRTH NO.

OCT 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051	d. STREET ADDRESS (If rural, give location) Rt. # 5

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Henry	c. (Last) Moore	4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 31, 1902	9. AGE (In years last birthday) 67 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Oklahoma	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leon C. Moore	BIRTHPLACE Oklahoma	14. MOTHER'S MAIDEN NAME Minnie Hollis	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 457-05-7198A	17. INFORMANT'S OWN SIGNATURE ✓ Mrs John Moore	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bronchiolar adenocarcinoma of lung c metastasis	6 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* May 26, 1969, *to* 27 Sept, 1969, *that I last saw the deceased alive on* 27 Sept, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE B. L. Holcomb 860 M.D. (Degree or title)	23b. ADDRESS Caldwell, Idaho	23c. DATE SIGNED 14 Oct 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 3	24b. DATE Oct. 3, 1969	24c. NAME OF CEMETERY OR CREMATORY Mt. View Crematory	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Oct. 17, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Rodney W. Dakan	LICENSE NO. E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 26 1937

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4643
Local Reg. No. 487
Reg. Dist. No. 360

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 15 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp. DOA 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 2123 Maple Street

3. NAME OF DECEASED (Type or Print)
a. (First): Richard
b. (Middle): Daniel
c. (Last): Weber

4. DATE OF DEATH (Month) (Day) (Year): Oct. 1, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 27, 1967
9. AGE (In years last birthday): 2 — IF UNDER 1 YEAR: Months 3, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant or
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Caldwell, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Freddie Weber — BIRTHPLACE: Caldwell, Idaho
14. MOTHER'S MAIDEN NAME: Linda Outram — BIRTHPLACE: Valley City, N. D.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Freddie S. Weber — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Accident — INTERVAL BETWEEN ONSET AND DEATH: INSTANT

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hit by truck
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Back of store
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Caldwell Canyon 13141 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Truck hit deceased

22. *I hereby certify that I attended the deceased from* Oct 1, 1969, *to* _____, 19__, *that I last saw the deceased alive on* never, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: John W. Gum 588 — (Degree or title): J. P. 5
23b. ADDRESS: Ct. House, Caldwell
23c. DATE SIGNED: 10/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 4, 69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Garden
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Oct. 14, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Lucy M. Flahiff
LICENSE NO.: E-393

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4644
Local Reg. No. 488
Reg. Dist. No. 360

RECEIVED OCT 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cayon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 3 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. View Terrace Nursing Home 360

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 565
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jordan Valley
d. STREET ADDRESS (If rural, give location): Rural Jordan Valley

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Charles	Edward	Dowell	Oct.	4,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Jan. 7, 1876	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher Cattleman 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm Cattle
11. BIRTHPLACE (State or foreign country): Pettis County, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William W. Dowell — BIRTHPLACE: Unk,
14. MOTHER'S MAIDEN NAME: Julia Glaze — BIRTHPLACE: Unk,
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 542-26-8434 A
17. INFORMANT'S OWN SIGNATURE: Margaret Keith — ADDRESS: Ontario

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

887X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardio-vasc Dis- — 20 yrs -
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Pyelonephritis & fracture left hip — 3 wks.

19a. DATE OF OPERATION: 16 July 69
19b. MAJOR FINDINGS OF OPERATION: Fracture left hip
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Fracture left hip
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21c. (CITY, TOWN, OR TOWNSHIP) Jordan valley (COUNTY) Mala (STATE) Ore 38555
21d. TIME OF INJURY (Month) July (Day) 14 (Year) 1969 (Hour) 9 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fall in home

22. *I hereby certify that I attended the deceased from* 26 Sept, 1969, *to* 4 Oct, 1969, *that I last saw the deceased alive on* 4 Oct, 1969, *and that death occurred at* 1:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 473 (Degree or title) M.D.
23b. ADDRESS: Caldwell
23c. DATE SIGNED: 10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Evergreen Ceme tery
24d. LOCATION (City, town, or county) (State): Ontario, Oregon

DATE REC'D BY LOCAL REG.: Oct. 14, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Robert J. Bertelson
LICENSE NO.: 222 Ore
FIRM NAME: Bertelson-Lienkaemper, Ontario

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4645
Local Reg. No. 482
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Blakley's Nursing Home (177)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho (13)
b. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Warren	Fredrick	Sponsler	Oct. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	Jan. 3, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (28)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Fredrick Sponsler — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Laura Drew — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: E. L. Sponsler — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 4047 Arteriosclerotic cardio-renal disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Benign Prostatic Hypertrophy & coronary thrombosis — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
October 3 m.		

22. *I hereby certify that I attended the deceased from* May 14, 1964, to Sept 3 Oct. 1969, *that I last saw the deceased alive on* Sept 18, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
J. W. Kellogg 315	MD	Caldwell, Idaho	10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 6, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 9, 1969	Mrs. Martine Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED OCT 20 1969

State File No. 4646
Local Reg. No. 493
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Bureau of
c. LENGTH OF STAY (In this place) 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor 30,

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First) Stella b. (Middle) M. c. (Last) Chase
4. DATE OF DEATH (Month) (Day) (Year) October 5, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Oct. 17, 1884
9. AGE (In years last birthday) 84 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife of
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Crete, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ezra F. Stephens BIRTHPLACE Somner, Maine
14. MOTHER'S MAIDEN NAME Mary E. Gregory BIRTHPLACE Michigan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-58-8362
17. INFORMANT'S OWN SIGNATURE ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cerebral Vascular Disease — 6 mo
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Fracture Rt. Hip 7-28-69
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-3 1948, to 10-5, 1969, that I last saw the deceased alive on 10-5, 1969, and that death occurred at 11:45p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) T C Horton MD
23b. ADDRESS 1223-7 St. So, Nampa
23c. DATE SIGNED 10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE Oct. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY Mt. View Crematory
24d. LOCATION (City, town, or county) Boise, (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 17, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Glen E. Sivers
LICENSE NO. E-498
FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4647
Local Reg. No. 490
Reg. Dist. No. 360

BIRTH NO. RECEIVED

1. PLACE OF DEATH a. COUNTY Canyon 142 OCT 15 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Bureau of Vital Statistics c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor Nursing Home 301	d. STREET ADDRESS (If rural, give location) 337 East State

3. NAME OF DECEASED (Type or Print) a. (First) Nancy	b. (Middle)	c. (Last) Ritchie	4. DATE OF DEATH (Month) (Day) (Year) 10 - 5 - 69	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 7-18-1885	9. AGE (In years last birthday) 84 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (State or foreign country) Manchester Co. Kent.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Asher	BIRTHPLACE Kentucky	14. MOTHER'S MAIDEN NAME Annie Holland	BIRTHPLACE Kentucky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-12-3024D	17. INFORMANT'S OWN SIGNATURE Mrs Martha Smith	ADDRESS Meridian R#2	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebro Vasc. Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1955 *19*___, *to* 10/5/ *, 19*69 *, that I last saw the deceased alive on* 10/4/69 *, 19*___, *and that death occurred at* 9 *m., from the causes and on the date stated above.*

23a. SIGNATURE J. Marcusen MD 326 (Degree or title)	23b. ADDRESS Nampa Idaho	23c. DATE SIGNED Oct. 9 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial 01	24b. DATE 10-9-69	24c. NAME OF CEMETERY OR CREMATORY Kuna Cemetery	24d. LOCATION (City, town, or county) (State) Kuna, Idaho
DATE REC'D BY LOCAL REG. Oct. 15, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Jack W. Green	LICENSE NO. E-528

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED NOV 20 1969 Bureau of Vital Statistics

State File No. 4648
Local Reg. No. 548
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital (057)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Box 256

3. NAME OF DECEASED (Type or Print): a. (First) Mae; b. (Middle) P.; c. (Last) Collins

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 13, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Eagle Bar, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Lovell — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Kathrene Larsen — BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-26-9602A
17. INFORMANT'S OWN SIGNATURE & ADDRESS: [signature]

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 2381 Cerebellar tumor Brain — INTERVAL BETWEEN ONSET AND DEATH: 5 months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1969 *to* Oct, 1969, *that I last saw the deceased alive on* Oct 7, 1969, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 10, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 19, 1969	Mrs. Martina Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 2 2 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4649
Local Reg. No. 491
Reg. Dist. No. 360

BIRTH NO.

RECEIVED STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 OCT 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa Bureau of Vital Statistics
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): V.
c. (Last): Howell

4. DATE OF DEATH (Month) (Day) (Year): 10 - 7 - 69

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 9-12-1903
9. AGE (In years last birthday): 66
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: same
11. BIRTHPLACE (State or foreign country): La Veta, Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alex Firm
BIRTHPLACE: Colorado
14. MOTHER'S MAIDEN NAME: Agnes Gale
BIRTHPLACE: unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 546-07-3605 A
17. INFORMANT'S OWN SIGNATURE: Albert Howell
ADDRESS: Kuna

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

426X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 2, 1969, *to* October 7, 1969, *that I last saw the deceased alive on* Oct. 6, 1969, *and that death occurred at* 12:06 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Marvin E Blough M.D. 130 (Degree or title)
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: Oct 9 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 10-9-69
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Oct. 15, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Jack H. Green
LICENSE NO.: E-528

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Robison Chapel of the Chimes

FEB 2 1970
JAN 21 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4650
Local Reg. No. 504
Reg. Dist. No. 360

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142 — OCT 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 7 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 415 Elder

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 415 Elder

3. NAME OF DECEASED (Type or Print): a. (First) Arthur — b. (Middle) C. — c. (Last) Lunn

4. DATE OF DEATH (Month) (Day) (Year): October 7, 1969

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Jan. 23, 1890

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Labor 06

10b. KIND OF BUSINESS OR INDUSTRY: Odd Jobs

11. BIRTHPLACE (State or foreign country): Edward, Mississippi

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dock Lunn — BIRTHPLACE: Edward, Miss.

14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I 3

16. SOCIAL SECURITY NO.: 441-28-8091

17. INFORMANT'S OWN SIGNATURE: Denton E Cox — ADDRESS: New York City, N.Y.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Burned To Death — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Fire in his home.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

890X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection only, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wenck 53 M.D. Coroner

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 13, 1969

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Oct. 23, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Glen L. Siren — LICENSE NO.: E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED OCT 22 1969 Bureau of Vital Statistics

State File No. 4651
Local Reg. No. 501
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell	c. LENGTH OF STAY (In this place)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051	d. STREET ADDRESS (If rural, give location): Rt. # 3

3. NAME OF DECEASED (Type or Print)	a. (First) Ellen	b. (Middle) Fay	c. (Last) Doty	4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: June 23, 1920	9. AGE (In years last birthday): 49 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Baker, Oregon	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Dow Adams	BIRTHPLACE: Texas	14. MOTHER'S MAIDEN NAME: Janet Scofield	BIRTHPLACE: Texas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 536-22-4992	17. INFORMANT'S OWN SIGNATURE: Jesse J. Doty	ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3d.

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Pancoast Tumor lung — 2yrs.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1967, *to* 10-8, 1969, *that I last saw the deceased alive on* 10-8, 1969, *and that death occurred at* 11 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 258 (Degree or title)	23b. ADDRESS: 222 East Logan	23c. DATE SIGNED: 10-7-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct. 13, 1969	24c. NAME OF CEMETERY OR CREMATORY: Nyssa Cemetery	24d. LOCATION (City, town, or county) (State): Nyssa, Oregon
DATE REC'D BY LOCAL REG.: Oct. 21, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: Rodney W. Dakan	LICENSE NO.: E-508

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 19 1969
JUL 12 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4652
Local Reg. No. 495
Reg. Dist. No. 360

BIRTH NO.

RECEIVED

STATE OF IDAHO

1. PLACE OF DEATH

a. COUNTY (41) Canyon OCT 20 1969

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell

c. LENGTH OF STAY (in this place) 1 day

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hosp. (05)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY Canyon (40)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Caldwell

d. STREET ADDRESS (If rural, give location) Route # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Frederick	W.	Park	Oct. 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Oct. 25, 1887	81	1	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (54)	Retired	Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-07-0017	Mrs. Merle Laeger	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Cardiovascular Disease — Indefinite

DUE TO (c) Vascular Disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Left Hemiplegia — 4 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 1968, *to* 10-8, 1969, *that I last saw the deceased alive on* 10-8, 1969, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Kennick MD	1819 Ella St Caldwell Idaho	10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 13, 69	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 17, 1969	Mrs. Martina Walmsley	Leonard T. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4653
Local Reg. No. 508
Reg. Dist. No. 360

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 28 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. View Nursing Home 360

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Homedale
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Vera
b. (Middle): M.
c. (Last): Davison

4. DATE OF DEATH (Month) (Day) (Year): Oct. 9, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6-13-1903
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months 3, Days 26 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Rhodes, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Mr. Weeks — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-40-1101
17. INFORMANT'S OWN SIGNATURE: X F. S. Davison — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Severe chronic bronchitis & emphysema
Recent cerebral vascular accident

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-22-69, 19__, *to* 10-9-69, 19__, *that I last saw the deceased alive on* 10-9-69, 19__, *and that death occurred at* 9:10A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Charles E. Reed 379 M.D.
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 10-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-13-1969
24c. NAME OF CEMETERY OR CREMATORY: Wilder Cemetery
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: Oct. 27, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard P. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Homedale's Flahiff Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 26 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased;
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4654
Local Reg. No. 516
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 — OCT 3 1 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 83651
d. STREET ADDRESS (If rural, give location): 924 13th Ave. South

3. NAME OF DECEASED (Type or Print)
a. (First): Casper
b. (Middle):
c. (Last): Sommer

4. DATE OF DEATH (Month) (Day) (Year): October 9, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 12, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Veterinarian 14
10b. KIND OF BUSINESS OR INDUSTRY: Livestock
11. BIRTHPLACE (State or foreign country): Lucerne, Switzerland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: No Record — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-40-1462
17. INFORMANT'S OWN SIGNATURE: Mrs. Casper Sommer — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Arteriosclerotic Heart Disease

~~DUE TO (c)~~ and: Pneumonia - Right Lower &

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Left Upper Lung

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 28 Sept 1969, *to* 9 Oct, 1969, *that I last saw the deceased alive on* 9 Oct, 1969, *and that death occurred at* 1:10 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J R Mangum MD 322
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 26 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mt C'lvary Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Oct. 30, 1969
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: Glen Siren
LICENSE NO.: E-498

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Shepherd Mortuary

DUTIES:

MAY 4 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 7 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 1 4 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 0 7 1993

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4655
Local Reg. No. 499
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) City, Middleton
d. STREET ADDRESS (If rural, give location) City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ernest	Everett	Walker	Oct. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	March 24, 1888	81	6	15		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bldg. Contractor //	Retired	Cameron, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
G.W. Walker	Missouri	Ella Black	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	535-18-2600A	Maurice E. Walker	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Carcinomatosis 1533	2 months
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Adenocarcinoma - Sigmoid Colon	2 years.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Right Subdural Hematoma Myocardial Fibrosis.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1969, *to* 9 Oct, 1969, *that I last saw the deceased alive on* 9 Oct, 1969, *and that death occurred at* 4:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Krause, M.D.	Caldwell Idaho	16 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-13-1969	Middleton Cemetery	Middleton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 1 4 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4656
Local Reg. No. 492
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 Canyon OCT 20 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 5 months
d. FULL NAME OF HOSPITAL OR INSTITUTION 703 10th Ave. south 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Canyon, 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Route 6

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) S. c. (Last) Crew

4. DATE OF DEATH (Month) (Day) (Year) October 10, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH August 26, 1880

9. AGE (In years last birthday) 89

IF UNDER 1 YR. Months | Days

IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker 01

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Lexington, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Vincent BIRTHPLACE Kentucky

14. MOTHER'S MAIDEN NAME Anna Holmes BIRTHPLACE Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-46-1256

17. INFORMANT'S OWN SIGNATURE Mrs E. C. Dabb ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 5 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A.S.H.D. — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/17/ , 19 67 to 10/10/ , 19 69 , that I last saw the deceased alive on 10/10/ , 19 69 , and that death occurred at 8:00a m., from the causes and on the date stated above.

23a. SIGNATURE Rutland C. Dwyer (Degree or title) M.D.

23b. ADDRESS 619 So. Canyon, Nampa, Idaho

23c. DATE SIGNED 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 13, 1969

24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) Nampa (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 17, 1969

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Glen S. Siren

LICENSE NO. E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 13 1970
SEP 29 1933

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4657
Local Reg. No. 522
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 NOV 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 812 Belmont St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Gertrude		Jordan	Oct. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	May 12, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Grant County, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
R. A. Williams	Ohio	Mary Latham	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-36-0855D	Shirley A. Wisel	Rt #1 Box 347 Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

2509

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pyelonephritis, Chronic

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5-6-60 *19*____, *to* 10-10-69 *19*____, *that I last saw the deceased alive on* 10-10-69 *19*____, *and that death occurred at* 11:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	178 MD	222 East Elm, Caldwell, Idaho	10-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 13.1969	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Mrs. Martin Walmsley	Kenneth E. Spencer	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

FEB 20 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4658
Local Reg. No. 503
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
OCT 23 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Memorial Hospital (057)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 702 S. 7th

3. NAME OF DECEASED (Type or Print): a. (First) Roy; b. (Middle) D.; c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year): Oct. 10, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 12, 1884

9. AGE (In years last birthday): 85
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ov
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Anthony, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James C. Smith
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Thedosia George
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mrs. R. L. Faris
ADDRESS: 160 E. Evergreen Dr. Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial Infarction, Probable — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Coronary Artery Disease Many years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NONE
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____ 19____ *, to* _____ , 19____ *, that I last saw the deceased alive on* _____ , 19____ *, and that death occurred at* 4:55 P.m., *from the causes and on the date stated above.* DEAD ON ARRIVAL

23a. SIGNATURE: L. David Johnson (Degree or title): MD
23b. ADDRESS: 1819 Ellis Ave, Caldwell, Ida.
23c. DATE SIGNED: 10/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: October 22, 1969
REGISTRAR'S SIGNATURE: Mrs. Martin's Walmsley
25. EMBALMER: Kenneth E. Greene
LICENSE NO.: E-395
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 2 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED OCT 27 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4659
Local Reg. No. 506
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 512 Freeport Street

3. NAME OF DECEASED (Type or Print)
a. (First): Harrison
b. (Middle): Orval
c. (Last): Wilson

4. DATE OF DEATH (Month) (Day) (Year): Oct. 10, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 1, 1906
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months 8, Days 21 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plastering 21
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Fairview, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clinton Wilson — BIRTHPLACE: Oklahoma
14. MOTHER'S MAIDEN NAME: Rosela Elwell — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-12-5208
17. INFORMANT'S OWN SIGNATURE: X Edwin L. Wilson — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

583X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic glomerulonephritis — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27-68, 19__, *to* 10-10-69, 19__, *that I last saw the deceased alive on* 10-10-69, 19__, *and that death occurred at* 3:45P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Walker M.D. 250
23b. ADDRESS: 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED: 10-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-14-1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 24, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

DUTIES: NOV 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4660
Local Reg. No. 500
Reg. Dist. No. 360

BIRTH NO.

OCT 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home, 1324 Arlington St. 000	d. STREET ADDRESS (If rural, give location) 1324 Arlington St.

3. NAME OF DECEASED (Type or Print)	a. (First) Thomas	b. (Middle) Walker	c. (Last) Hatten	4. DATE OF DEATH (Month) (Day) (Year) Oct. 12, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 17, 1894	9. AGE (In years last birthday) 75 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Jamestown, North Dakota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Jefferson Hatten	BIRTHPLACE Minnesota	14. MOTHER'S MAIDEN NAME Mary E. Walker	BIRTHPLACE Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) War I 3	16. SOCIAL SECURITY NO. 519-20-1580	17. INFORMANT'S OWN SIGNATURE Mrs Tom Hatten	ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction	5 min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	A.S.H.D.	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Essential Hypertension	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1966, *to* Oct 12, 1969, *that I last saw the deceased alive on* Aug 6, 1969, *and that death occurred at* 5A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 258 (Degree or title)	23b. ADDRESS 222 East Logan	23c. DATE SIGNED 10-16-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 14, 1969	24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho		
DATE REC'D BY LOCAL REG. Oct. 21, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Kenneth E. Spence
LICENSE NO. E-395		

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4661
Local Reg. No. 497
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 140
a. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
c. LENGTH OF STAY (In this place) 52 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route 5

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
d. STREET ADDRESS (If rural, give location) Route 5

3. NAME OF DECEASED (Type or Print)
a. (First) Thomas
b. (Middle) F.
c. (Last) Fry

4. DATE OF DEATH (Month) (Day) (Year) Oct. 13, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 27, 1885
9. AGE (In years last birthday) 84
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Nevada, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Fry
BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Elizabeth Bryant
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 40 2230
17. INFORMANT'S OWN SIGNATURE X Wendell Allen
ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occl.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/24, 1964 *to* 10/ , 1969, *that I last saw the deceased alive on* 10/ , 1969, *and that death occurred at* 8 ccp. *m., from the causes and on the date stated above.*

23a. SIGNATURE S. C. Tay, MD (Degree or title)
23b. ADDRESS 619 Canyon
23c. DATE SIGNED 10/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-18-69
24c. NAME OF CEMETERY OR CREMATORY Hill Crest Memorial Gardens
24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. Oct. 20, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER M. B. Shepherd
LICENSE NO. 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4662
Local Reg. No. 498
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 21 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 140 Canyon
b. CITY OR TOWN Rural, Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 5, 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Caldwell
d. STREET ADDRESS (If rural, give location) Route # 5

3. NAME OF DECEASED (Type or Print)
a. (First) Carl
b. (Middle) John
c. (Last) Kistner

4. DATE OF DEATH (Month) (Day) (Year) Oct. 13, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 11-22-1914

9. AGE (In years last birthday) 54
IF UNDER 1 YEAR: Months 10 | Days 21
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transport Driver

10b. KIND OF BUSINESS OR INDUSTRY Ideal Corp.

11. BIRTHPLACE (State or foreign country) Botkins, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Albin Kistner
BIRTHPLACE Botkins, Ohio

14. MOTHER'S MAIDEN NAME Victoria Gearheart
BIRTHPLACE Botkins, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WWII 4

16. SOCIAL SECURITY NO. 289-09-9131

17. INFORMANT'S OWN SIGNATURE Mrs. Nita Kistner
ADDRESS

18. CAUSE OF DEATH 4189
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coroner Occlusion
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection and history, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 12:15 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Wesche 583 4 (Degree or title) M. D. Coroner

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED 10-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-16-1969

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 20, 1969

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Leonard C. Flahiff

LICENSE NO. E-481

FIRM NAME: Flahiff Funeral Charel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4663
Local Reg. No. 515
Reg. Dist. No. 360

BIRTH NO.

OCT 3 1 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa c. LENGTH OF (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050	d. STREET ADDRESS (If rural, give location): 107 Fern

3. NAME OF DECEASED (Type or Print) a. (First): CLARA	b. (Middle): M.	c. (Last): ZENOR	4. DATE OF DEATH (Month) (Day) (Year): October 13, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Feb. 21, 1896	9. AGE (In years last birthday): 73 — IF UNDER 1 YR. Months Days: - - — IF UNDER 24 HRS. Hours Min.: - - - -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Boone, Iowa	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Fred Blaess	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Mary Laniger	BIRTHPLACE: Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - - - - - -	16. SOCIAL SECURITY NO.: 319-05-1945	17. INFORMANT'S OWN SIGNATURE: Thomas R Zenor	ADDRESS: Nampa, Idaho	

5718

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Liver failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Biliary Cirrhosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-6-69	19b. MAJOR FINDINGS OF OPERATION: See above	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1-69, 19____, *to* 10-13-69, 19____, *that I last saw the deceased alive on* 10-12-69, 19____, *and that death occurred at* 12:15p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 2718 (Degree or title) MD	23b. ADDRESS: 321 Roosevelt Ave	23c. DATE SIGNED: 10/29/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct. 16, 1969	24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery	24d. LOCATION (City, town, or county) (State): Canyon County Idaho
DATE REC'D BY LOCAL REG.: Oct. 30, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: Marvin R. Heikkila	LICENSE NO.: 515

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4664
Local Reg. No. 505
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna- Rural
d. STREET ADDRESS (If rural, give location): R# 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARY	C.	EMERT	October	14,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 16, 1882	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Tennessee	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Ogle	No Record	Sarah Langston	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	541 60 4006	X Mrs. Frank Ward	R#1, Kuna, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 d

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cerebral Vascular Disease — 2 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hydronephosis Rt — 3 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐ X

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-13, 1957 *to* 10-14, 1969, *that I last saw the deceased alive on* 10-10, 1969, *and that death occurred at* 7:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J C Horton MD	1223-7 St So Nampa	10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10/15/69	Olney Cemetery	Pendleton, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 23, 1969	Mrs. Martina Walmsley		E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

State File No. 4665
Local Reg. No. 510
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa c. FACILITY OF STAT (If this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor	d. STREET ADDRESS (If rural, give location) 512-17 Avenue South

3. NAME OF DECEASED (Type or Print)	a. (First) MABEL	b. (Middle) L.	c. (Last) PRITCHETT	4. DATE OF DEATH (Month) October (Day) 14, (Year) 1969
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 16, 1888	9. AGE (In years last birthday) 81 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Blue River Wisconsin	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harmon Peer	BIRTHPLACE Wisconsin	14. MOTHER'S MAIDEN NAME Elsie Hulbert	BIRTHPLACE Wisconsin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518 54 3256	17. INFORMANT'S OWN SIGNATURE x Camilla Shea	ADDRESS Nampa, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1841

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Senility,	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertension	
DUE TO (c)	Carcinoma of Vulva.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 9-23-69, 19___, *to* 9-26-69, 19___, *that I last saw the deceased alive on* 9-26, 1969, *and that death occurred at* 5:25P. *m., from the causes and on the date stated above.*

23a. SIGNATURE S E Lisk, 83 (Degree or title) MD	23b. ADDRESS 1305 3rd So, Nampa	23c. DATE SIGNED 10-22-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/17/1969	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery	24d. LOCATION (City, town, or county) Ada County (State) Idaho
DATE REC'D BY LOCAL REG. Oct. 27, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Richard W Mesenbrink	LICENSE NO. E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 9 1969
APR 1 5 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 22 1969 Bureau of Vital Statistics

State File No. 4666
Local Reg. No. 502
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) few Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 219 Almond

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alvin	(nmn)	Choat	Oct. 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 14, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
filter Foreman 26	Sugar Factory	Madison, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William S. Choat	Iowa	Grace E. Earl	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 05 7164	X Grace Choat	Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from history only., 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 5:45P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche 583 M.D. Coroner. 4	Nampa, Idaho	10-20-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-20-69	Hillcrest Memorial Gardens	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 21, 1969	Mrs. Martin Walmsley	Shepherd Mortuary	473

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 4 1969

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4667
Local Reg. No. 526
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN: Caldwell
c. LENGTH OF STAY (In this place): 7 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial (051)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette (380)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
d. STREET ADDRESS (If rural, give location): 412 Whitley Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Wallace; b. (Middle) NMN; c. (Last) Gerth

4. DATE OF DEATH: (Month) Oct (Day) 17 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 29 1888

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool Maker (24)

10b. KIND OF BUSINESS OR INDUSTRY: Machinest

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Theordor Gerth
BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Mary Wallace
BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 572-20-8815A

17. INFORMANT'S OWN SIGNATURE: Marie Gerth
ADDRESS: Fruitland, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1570

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma, head of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-29-69, 19___, *to* 10-17-69, 19___, *that I last saw the deceased alive on* 10-17-69, 19___, *and that death occurred at* 1:20p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W W Huber MD (250)

23b. ADDRESS: 222 East Elm, Caldwell, Idaho

23c. DATE SIGNED: 10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial (3)

24b. DATE: 10-17-69

24c. NAME OF CEMETERY OR CREMATORY: Rosedale

24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: Nov. 5, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Donald F Brown

LICENSE NO.: E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4668
Local Reg. No. 532
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital OSP

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 2904 Garrity Blvd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Octave	Joseph	VanWassenhove	Oct. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	Oct. 15, 1884	85	0	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railroad So. Pacific	Retired	Oostwinkel, Belgium	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edmond VanWassenhove	Belgium	R. Lootens	Belgium

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	700-09-5010	x Joseph VanWassenhove	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebro Vasc Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/1, 19 69, *to* 10/17, 19 69, *that I last saw the deceased alive on* 10/17, 19 69 *and that death occurred at* 3A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J.D. Marcum 326 MD	Nampa Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-20-1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Nov. 7, 1969	Mrs. Martina Walmsley	Embalmer Leonard C. Flahiff	License No E-481

Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 27 1970

JUN 23 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

[redacted] RESIDENCE OF DECEASED

[redacted] of the fact that the person [redacted] have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. If person [redacted] in the County where death occurred for less than one year, give [redacted] of the deceased may be in a county or state other than the county of [redacted].

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4669
Local Reg. No. 511
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY (42) Canyon — OCT 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa — Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) months

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho — b. COUNTY Canyon (42)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 119 1/2 Diamond Street

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Midland Manor Home (30)

3. NAME OF DECEASED (Type or Print) — a. (First) PEARL — b. (Middle) INEZ — c. (Last) YOUNT

4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 21, 1904
9. AGE (In years last birthday): 65
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (01)
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Reedsburg, Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mahlon Hutchens — BIRTHPLACE: Wisconsin
14. MOTHER'S MAIDEN NAME: Lydia Sloniker — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-64-4666
17. INFORMANT'S OWN SIGNATURE: x Iona Klemis — ADDRESS: Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary ASHD (4123)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cystitis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Rheumatoid Arthritis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1965, to Oct, 1969, that I last saw the deceased alive on Oct 15, 1969, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) — 23b. ADDRESS — 23c. DATE SIGNED 23 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/22/69
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: Oct. 27, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Larry S. Franck
LICENSE NO.: E-447
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 30 1969 Bureau of Vital Statistics

State File No. 4670
Local Reg. No. 514
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa c. LENGTH OF STAY (In this place): years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital- 050	d. STREET ADDRESS (If rural, give location): 211 16th Ave. So.,

3. NAME OF DECEASED (Type or Print)	a. (First) FRANCIS	b. (Middle) (FRANK)	c. (Last) MAYHUGH	4. DATE OF DEATH (Month) (Day) (Year) Oct. 18, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single	8. DATE OF BIRTH: Dec, 29, 1880	9. AGE (In years last birthday): 88 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 04	10b. KIND OF BUSINESS OR INDUSTRY: Farmer	11. BIRTHPLACE (State or foreign country): Marion County, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: James Mayhugh	BIRTHPLACE: Ohio	14. MOTHER'S MAIDEN NAME: Malinda Schonevly	BIRTHPLACE: Kansas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Spanish-Amer. 1	16. SOCIAL SECURITY NO.: 518-18-7127	17. INFORMANT'S OWN SIGNATURE: Family Records, By: [signature]	ADDRESS:	

898 X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bean 3° 30%	4 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	cigarette lighter fluid ignition	
DUE TO (c)	mental confusion on part of patient	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes, Gen arteriosclerosis	20 yr

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT X SUICIDE HOMICIDE 1 (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 13 Golden Guest Nursing Home	21c. (CITY, TOWN, OR TOWNSHIP) Nampa	(COUNTY) Canyon 13142 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 6/1/ *, 19* 64 *, to* 10/18/ *, 19* 69 *, that I last saw the deceased alive on* 10/18/ *, 19* 69 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 064 [signature] (Degree or title)	23b. ADDRESS 619 So. Canyon, Nampa, Idaho	23c. DATE SIGNED 10/25/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10/21/69	24c. NAME OF CEMETERY OR CREMATORY: Wilder Cemetery	24d. LOCATION (City, town, or county) (State): Wilder, Canyon, Idaho
DATE REC'D BY LOCAL REG.: Oct. 29, 1969	REGISTRAR'S SIGNATURE: Irene N. Kantz RN	25. EMBALMER: Larry S. Krouch	LICENSE NO.: E-447

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4671
Local Reg. No. 518
Reg. Dist. No. 360

BIRTH NO.

OCT 3 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF DAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051	d. STREET ADDRESS (If rural, give location) 2204 Locust

3. NAME OF DECEASED (Type or Print) a. (First) Edna	b. (Middle) M.	c. (Last) Weymouth	4. DATE OF DEATH (Month) (Day) (Year) Oct. 20, 1969		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 14, 1900	9. AGE (In years last birthday) 69	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Caldwell, Idaho	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ira Allen White	BIRTHPLACE Idaho	14. MOTHER'S MAIDEN NAME Lullie May Smith	BIRTHPLACE Idaho		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-01-9075D	17. INFORMANT'S OWN SIGNATURE x Mrs. Charlotte M. Posey	ADDRESS		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Rheumatoid arthritis severe — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pelvic abscess - septicemia — one year
DUE TO (c) Congestive heart failure

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Cystic spleen - Fatty infiltration pancreas.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1949, 19__, *to* 10-20, 1969, *that I last saw the deceased alive on* 10-20, 1969, *and that death occurred at* 6:A *m., from the causes and on the date stated above.*

23a. SIGNATURE 166 [signature] (Degree or title)	23b. ADDRESS Caldwell Ida	23c. DATE SIGNED 10-25-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 22, 1969	24c. NAME OF CEMETERY OR CREMATORY Wilder Cemetery	24d. LOCATION (City, town, or county) (State) Wilder, Idaho
DATE REC'D BY LOCAL REG. Oct. 30, 1969	REGISTRAR'S SIGNATURE Mrs Martina Walmsley	25. EMBALMER Kenneth E. Spence	LICENSE NO. E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 3 1 1969

DEC 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4672
Local Reg. No. 509
Reg. Dist. No. 360

RECEIVED OCT 28 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place) 2mth5day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 051 Caldwell Memorial Hospl

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 217 So. 13th

3. NAME OF DECEASED (Type or Print) a. (First) Mildred b. (Middle) G. c. (Last) Bow

4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Feb. 13, 1891

9. AGE (In years last birthday) 78 IF UNDER 1 YEAR Months 8 Days 8 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Whitewright, Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harvey Benedict BIRTHPLACE Woodburn, Ky.

14. MOTHER'S MAIDEN NAME Rosalee Marshall BIRTHPLACE Kentuckytown, Texa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 455-78-7785X

17. INFORMANT'S OWN SIGNATURE Claudine G Doyle ADDRESS 2 Heather Drive Hooksett N.H.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 16 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardio vascular disease 20 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cholithiasis fracture left hip

19a. DATE OF OPERATION 17 Aug 1969

19b. MAJOR FINDINGS OF OPERATION Fracture left hip

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT ☑ SUICIDE ☐ HOMICIDE ☐ (Specify) 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) left hip 01

21c. (CITY, TOWN, OR TOWNSHIP) Caldwell 13,41 (COUNTY) Canyon (STATE) Idaho

21d. TIME OF INJURY (Month) Aug (Day) 15 (Year) 1969 (Hour) 8am.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21f. HOW DID INJURY OCCUR? Fall in home

22. I hereby certify that I attended the deceased from 15 aug, 1969, to 21 oct, 1969, that I last saw the deceased alive on 21 oct, 1969, and that death occurred at 1:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE [signature] 473 (Degree or title) M.D.

23b. ADDRESS Caldwell

23c. DATE SIGNED 23 oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-23-1969

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 27, 1969

REGISTRAR'S SIGNATURE Mrs Martin Walmsley

25. EMBALMER Lucy M. Flahiff

LICENSE NO. E-393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 12 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4673
Local Reg. No. 521
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Blakley's Nursing Home (122)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Earl	C.	Clary	Oct. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	July 19, 1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer (64)		Arappahoe, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. W. Clary	Nebraska	Cora Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-05-4221A	Dale Clary	Parma, Idaho

4124

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Advanced Arteriosclerotic Cardio vascular disease with pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: several days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Emphysema — uncertain

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Prostatism with urinary retention requiring an indwelling Catheter — 2 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ____, 19 51 to 10 22, 19 69, that I last saw the deceased alive on 10-24, 19 69, and that death occurred at 5 A m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Kimick (280)	MD	1819 Ellis St Caldwell Idaho	10-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 25, 1969	Parma Cemetery	Parma, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Mrs. Martina Walmsley	James R. Dakan	E-785

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4674
Local Reg. No. 512
Reg. Dist. No. 360

BIRTH NO. Amended 7/6/79

RECEIVED
OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 112 Ivy

3. NAME OF DECEASED (Type or Print)
a. (First) JOHANNE
b. (Middle) FRAUKELINE
c. (Last) ELSEN

4. DATE OF DEATH (Month) October (Day) 22, (Year) 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 8/18/1885
9. AGE (In years last birthday) 84
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Westrhauderfehn, Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Bernhard Meyer
BIRTHPLACE Ostrhauderfehn Germany
14. MOTHER'S MAIDEN NAME Christine Laaken
BIRTHPLACE Westrhauderfehn, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no
17. INFORMANT'S OWN SIGNATURE x Rose H Gibbs
ADDRESS San Francisco California

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1959

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma Neck + Upper back

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-3- *1954, to* 10-22- *, 1969, that I last saw the deceased alive on* 10-22- *, 1969, and that death occurred at* 10:05P. *m., from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Wische 560 M.D. (Degree or title)
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/27/69
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) Nampa Canyon (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 27, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Marvin R. Hillila
LICENSE NO. 515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

NOV 1 2 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG-31 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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6/15/79

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

RECEIVED
VITAL STATISTICS
JUL 6 1 58 PM '79

State of _____ } ss.
County of _____

Certificate No. 69-4674
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of Death
for Johanne Fraukeline Elsen (Name on Original Certificate) who died (Was Born, Died, etc.) _____ on 10/22/69 (Date of Event)
in Nampa, Idaho (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
Father's birthplace	Holland	Ostrhauderfehn, Germany
Mother's birthplace	Germany	Westrhauderfehn, Germany

Subscribed and sworn to before me this 15th day of June, 1979.

Notary Public, Margaret D. Davis
Residing at _____
My commission expires, Lifetime
(Seal)

MARGARET D. DAVIS NOTARY PUBLIC STATE OF IDAHO

Lena C. Davis
Signature of Applicant

112 11th Nampa Ida
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ } ss.
County of _____

(Must be completed ___)
(Is not necessary ___)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, 19___.

Notary Public, _____
Residing at _____
My commission expires _____
(Seal)

_____
Supporting Signature

_____
Street Address, City, State

Information listed in Song book written by Bernhard Meyer gives place of birth of Bernhard Meyer as Ostrhauderfehn, Germany and the birth place of Christina Laaken as Westrhauderfehn. Book is very old (1873). viewed by V.S.

JUL 6 1979

MAR 5 1981
MAR 6 1981
MAR 12 1981

Information in old document states that the farmer, Reinhard Elsen and his wife, Johanne, born Meyer, are from Guelph North Dakota, North America, and that Mrs. Elsen's parents are Bernhard Meyer and Christine born Laaken at Westrhsuderfehn. This was sealed and certified on December 3, 1913. Viewed by V.S.

Certificate of Death

STATE OF IDAHO

State File No. 4675
Local Reg. No. 527
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Midland Manor Nursing Home 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 424 W. Washington
d. STREET ADDRESS (If rural, give location) Nampa, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Carroll	M.	Crew	Oct. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	April 18, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Columbia Co., Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Mahlon Crew — BIRTHPLACE Pa.
14. MOTHER'S MAIDEN NAME Phoebe Ann Hoopes — BIRTHPLACE Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-1119
17. INFORMANT'S OWN SIGNATURE Elmer C. Cryer — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebro Vascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arthritis — 6-8 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Parkinsonism

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10 Jan, 67, to Oct, 19 69, that I last saw the deceased alive on Oct 20, 19 69 and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Chandler Olsen MD	Nampa Idaho	24 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 27, 1969	Greenleaf Cemetery	Greenleaf, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1969	Mrs. Martin Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 0 4 2005

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4676
Local Reg. No. 513
Reg. Dist. No. 360

RECEIVED
OCT 30 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 122 Cleveland Blvd. ooo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 122 Cleveland Blvd.

3. NAME OF DECEASED (Type or Print)
a. (First): Shirley
b. (Middle): Dou
c. (Last): Murray

4. DATE OF DEATH: October 23, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 8-26-1923

9. AGE (In years last birthday): 46
IF UNDER 1 YEAR — Months: 1 Days: 27
IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Victor, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alfred G. Kadel
BIRTHPLACE: Victor, Kansas

14. MOTHER'S MAIDEN NAME: Freda Evans
BIRTHPLACE: Beloit, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: X John L. Murray
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Abdominal Carcinomatosis
INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cancer of left breast

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9.20.68

19b. MAJOR FINDINGS OF OPERATION: Ca of left breast - poss. Ca of liver

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-12-68, 19____, *to* 10-6-69, 19____, *that I last saw the deceased alive on* 10-6-69, 19____, *and that death occurred at* 6:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John R. McClain M.D.

23b. ADDRESS: 303 E. Logan Caldwell, Idaho

23c. DATE SIGNED: 10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-25-1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): near Nampa, Idaho

DATE REC'D BY LOCAL REG.: Oct. 29, 1969

REGISTRAR'S SIGNATURE: Irene M. Kantola

25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 3 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 2 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 9 1979

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4677
Local Reg. No. 524
Reg. Dist. No. 360

STATE OF IDAHO

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1203 Willow

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1203 Willow

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Morrison	Brown	Oct 24 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 3, 1912	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
clerk 10	U. P. Railroad	Halls, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
A. D. Brown	Halls, Missouri	Althea Morrison	Rushville, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WWII & Korean	519-44-2855	Mrs Wm M Brown	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Stem Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1½ hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen. Cerebral Arteriosclerosis — 3 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/18, 1969, *to* 10/16, 1969, *that I last saw the deceased alive on* 10/16, 1969, *and that death occurred at* 2pm *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald W Brown MD	619 S Canyon	10/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 28, 1969	Hillcrest	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 5, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4678
Local Reg. No. 517
Reg. Dist. No. 360

BIRTH NO. 69-10221 RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 42 Canyon
OCT 3 1 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 12 Hrs.
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 332 Westwood Blvd.

3. NAME OF DECEASED (Type or Print)
a. (First): Bruce
b. (Middle): Patrick
c. (Last): Harvey

4. DATE OF DEATH (Month) (Day) (Year): Oct. 24, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Oct. 23, 1969

9. AGE (In years last birthday) | IF UNDER 1 YR. Months | Days | IF UNDER 24 HRS. Hours: 12 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ****** 02

10b. KIND OF BUSINESS OR INDUSTRY: ******

11. BIRTHPLACE (State or foreign country): Nampa, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas M. Harvey
BIRTHPLACE: Nampa, Idaho

14. MOTHER'S MAIDEN NAME: Mary Ann Dominick
BIRTHPLACE: Nampa, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Thomas M. Harvey
ADDRESS: Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pulmonary Hypoplasia 7589

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Congenital abnormal developmt
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes XX No

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-23, 1969, *to* 10-24, 19 69, *that I last saw the deceased alive on* 10-24, 19 69, *and that death occurred at* 5:10A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eugene A. Brown M.D.

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-27-69

24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Oct. 30, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: M. B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4679
Local Reg. No. 519
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 140	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, Route #6 c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, Route #6
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000	d. STREET ADDRESS (If rural, give location) Route #6

3. NAME OF DECEASED (Type or Print)	a. (First) RUTH	b. (Middle) LENORE	c. (Last) HOKOM	4. DATE OF DEATH (Month) (Day) (Year) Oct. 24, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 21, 1922	9. AGE (In years last birthday) 47 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher 12	10b. KIND OF BUSINESS OR INDUSTRY teaching	11. BIRTHPLACE (State or foreign country) Nebraska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Earl Welch	BIRTHPLACE Nebraska	14. MOTHER'S MAIDEN NAME Bess Stetson	BIRTHPLACE Nebraska	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - - - -	16. SOCIAL SECURITY NO. 508-18-6702	17. INFORMANT'S OWN SIGNATURE x Nelson Hokom	ADDRESS Nampa, Idaho	

18. CAUSE OF DEATH 174X

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of breast

DUE TO (c) c̄ generalized

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Metastases

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/13, 1967, *to* 10/24, 1969, *that I last saw the deceased alive on* 9/30, 1969, *and that death occurred at* 1:15a. *m., from the causes and on the date stated above.*

23a. SIGNATURE S. C. [signature] 524 (Degree or title) MD	23b. ADDRESS 619 Canyon Nampa	23c. DATE SIGNED 10/28/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/27/69	24c. NAME OF CEMETERY OR CREMATORY Hill Crest Memorial Gardens	24d. LOCATION (City, town, or county) Canyon Co. (State) Idaho
DATE REC'D BY LOCAL REG. Oct. 31, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Marvin R. [signature]	LICENSE NO. E-515

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 6 1969
DEC 4 1969
MAR 18 1970
SEP 13 1977
NOV 5 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4680
Local Reg. No. 542
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakeley Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 210 Cleveland Blvd.

3. NAME OF DECEASED (Type or Print)
a. (First): Gertrude
b. (Middle): Le Roie
c. (Last): Slattery

4. DATE OF DEATH (Month) (Day) (Year): Oct. 24, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 14, 1890

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 21

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Sedalia, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alex MacGregor
BIRTHPLACE: South Dakota

14. MOTHER'S MAIDEN NAME: Anna Argenbright
BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 537-26-3054

17. INFORMANT'S OWN SIGNATURE: X Thelma M. McCurry
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Generalized Arteriosclerosis with cerebral vascular insufficiency

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Large sacral stasis ulcer

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-3-68, 19____, *to* 10-24-69, 19____, *that I last saw the deceased alive on* 10-24-69, 19____, *and that death occurred at* 9:15P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Charles E. Ford M.D. 379
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 10-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-28-1969
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 13, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 10 1969 Bureau of Vital Statistics

State File No. 4681
Local Reg. No. 529
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 544 6th Road North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Blennie	F.	Frei	Oct. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Nov. 23, 1908	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Rexburg, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin Franklin Fife	Utah	Jessemin Warner	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-36-1428	x Ilene Wood	Grand View

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 4-5-60, 19____, to 10-25-69, 19____, that I last saw the deceased alive on 10-25-69, 19____, and that death occurred at 3:P.M. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
MD	222 East Elm, Caldwell, Idaho	10--30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 28, 1969	Hillcrest Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 7, 1969	Mrs. Martin C. Walmsley	Richard W. Messenbrink	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 12 1969

NOV 14 1969

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4682
Local Reg. No. 530
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (1)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (1)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1705 Arthur

3. NAME OF DECEASED (Type or Print): a. (First) Albert; b. (Middle) K; c. (Last) Dunn

4. DATE OF DEATH: (Month) Oct. (Day) 27, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 10, 1904

9. AGE (In years last birthday): 65
IF UNDER 1 YR. Months: 8 Days: 17
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): oo

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert Lewis Dunn
BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Mary Flood
BIRTHPLACE: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 502-09-5338-A

17. INFORMANT'S OWN SIGNATURE: Hattie K. Dunn
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary insufficiency
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: 1 = Cystoscopy polypectomies 2 = Kyphoscoliosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-17, 1969, *to* 10-27, 1969, *that I last saw the deceased alive on* 10-27, 1969, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD

23b. ADDRESS: Caldwell Ida

23c. DATE SIGNED: 10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 31, 1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 7, 1969

REGISTRAR'S SIGNATURE: Mrs Martin Walmsley

25. EMBALMER: W. Dewey W. Dakan

LICENSE NO.: E-508

FIRM NAME: Dakan Funeral Chapel Cald., Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 19 1969

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. DEC 12 1969
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED NOV 12 1969 Bureau of Vital Statistics

State File No. 4683
Local Reg. No. 535
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital (051)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Box 536

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edna	Chella	Fuller	Oct. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	Feb. 25, 1895	74	8	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
teacher (12)	education	Smith Center, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Kirk Landers	Kentucky	Lydia Byers	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No	518-07-9973	X Francis Payne

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Intracranial bleeding — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
	06	00000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Oct 25 1969 m.		auto accident

22. I hereby certify that I attended the deceased from Feb 2, 1963, to 27 Oct, 1969, that I last saw the deceased alive on 27 Oct, 1969, and that death occurred at 6 Am., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
W Mulkern 250 (Degree or title)	222 E. Elm St. Caldwell	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 30, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Irene N. Konle RR	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 4684
Local Reg. No. 528
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon (47) NOV 7 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Canyon (47)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell

LENGTH OF STAY (In this place)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Caldwell Memorial Hospital (057)

d. STREET ADDRESS (If rural, give location) 1317 Elgin St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Noah	R.	House	Oct. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 21, 1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Night Watchman (06)	Trailer Factory	Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph House		Laura Mattney	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	721-14-1904	Naomi House	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5513

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Massive pulmonary embolization.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Surgery for hiatal hernia	6 days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-22-69	Hiatal hernia	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-12-69, 19____, *to* 10-28-69, 19____, *that I last saw the deceased alive on* 10-28-69, 19____, *and that death occurred at* 10:15a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. M. Palrang, M.D.	M.D.	227 E. Logan, Caldwell, Idaho	11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 31, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1969	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Funeral Chapel Caldwell, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

NOV 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 1 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4685
Local Reg. No. 539
Reg. Dist. No. 360

RECEIVED NOV 13 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Caldwell
c. LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Caldwell Memorial Hosp. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 140
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Caldwell
d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print) a. (First) Ruth b. (Middle) M. c. (Last) Jamison

4. DATE OF DEATH (Month) (Day) (Year) October 28, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Aug. 10, 1898

9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months 2 Days 18 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 61

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Seward, Oklahoma

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lacy E. Alter BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Lela Sayer BIRTHPLACE Stella, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-40-2362

17. INFORMANT'S OWN SIGNATURE X T. J. Jamison ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

0092

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Abscess, Metastatic — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pericardial Abscess (Staphylococcal) — 1 week

DUE TO (c) Gastroenteritis (Probable Staphylococcal) — 1-2 weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bilateral Bronchopneumonia, moderate — 4 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/4, 1969, to 10/28, 1969, that I last saw the deceased alive on 10/28, 1969, and that death occurred at 6:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE L. David Johnson 884 (Degree or title) MD

23b. ADDRESS 1819 Ellis Ave, Caldwell, Ida.

23c. DATE SIGNED 11/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-31-1969

24c. NAME OF CEMETERY OR CREMATORY Star Cemetery

24d. LOCATION (City, town, or county) (State) Star, Idaho

DATE REC'D BY LOCAL REG. Nov. 12, 1969

REGISTRAR'S SIGNATURE Mrs Martina Walmsley

25. EMBALMER Leonard C. Flahiff

LICENSE NO. E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 5 1969
Bureau of Vital Statistics

State File No. 4686
Local Reg. No. 523
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (42)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (42)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 318 Yale St.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (050)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
STELLA	G.	McDANIEL	Oct. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	June 23, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	At Home	Fullerton, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Irvin Pepper	Iowa	Margaret Paro	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	553-38-9283A	x Clyde McDaniel	Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute cardiac dilatation due to decreased (4109) INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with acute myocardial infarct
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/21/ 69 *to* 10/28/ 69 *that I last saw the deceased alive on* 10/28/ 69 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Calvert Colley, 217 (Degree or title)	619 So. Canyon, Nampa, Idaho	10/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial (1)	10/30/69	Cloverdale Cemetery	Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	26. EMBALMER	LICENSE NO.
Nov. 4, 1969	Mrs. Martina Walmsley	Richard W. Mesubrink	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4687
Local Reg. No. 525
Reg. Dist. No. 360

RECEIVED NOV 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN Caldwell (If outside corporate limits, write RURAL and give township) | LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION Caldwell Memorial Hosp. 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Calif. 05 b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mentone
d. STREET ADDRESS (If rural, give location) P.O. Box 512

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	Arthur	Dolan	Oct. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 15, 1940	29	9 / 14	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
22	Self	So. Gate, Calif.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur T. Dolan	California	Teresa Lux	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	568-52-8008	X Sharon Lettie Dolan	632 S. E. Ontario Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
1	06	00000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Oct 29 69 4 m.		auto accident

22. I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hal E Reynolds 437 M	Caldwell Idaho	Nov 3-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-31-1969	Holy Cross Cemetery	Los Angeles, Calif.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 5, 1969	Mrs. Martina Walmsley	Leonard P. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 12 1969 Bureau of Vital Statistics

State File No. 4688
Local Reg. No. 538
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (In this place) 27 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 115 18th Ave. South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alma	I.	Rapple	Oct. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Feb. 22, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Maker 01	At Home	Sacramento, California	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Marshall	No Record	Elizabeth Lineberger	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519 24 7628	Mrs Mildred Breeding	Hazelton, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 450X Probable acute pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Erythema multiforme Stevan Johnsons syndrome — 3 wks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 10, 1969, to Oct 29, 1969, that I last saw the deceased alive on Oct 29, 1969, and that death occurred at 6:02P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Warren E Blough 730	Nampa, Idaho	11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-5-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Irene N. Kuntz RN	M. B. Shepherd	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4689
Local Reg. No. 531
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East of Cald on U. S. #30

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Caldwell
d. STREET ADDRESS (If rural, give location) Rt. # 1

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Henry c. (Last) Bennett

4. DATE OF DEATH (Month) (Day) (Year) Oct. 30, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 27, 1925
9. AGE (In years last birthday): 43
IF UNDER 1 YR. Months: 11 Days: 3
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Ovid, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ray Bennett
BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Cyntha Woodhams
BIRTHPLACE: Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Gloria C. Bennett
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8180

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed Chest
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Extensive Lacerations around right groin area

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) On highway East of 06
21c. (CITY, TOWN, OR TOWNSHIP) Caldwell, Canyon Co 13140 (COUNTY) (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 30 1969 11:20 A.M. ☒
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Tractor axle broke. Pinned him under tractor

22. I hereby certify that I attended the deceased from Inspection only 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____m., from the causes and on the date stated above.

23a. SIGNATURE Henry C. Wiesche 583 4 (Degree or title) M. D. Coroner
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED II-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 3, 1969
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 7, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Rodney W. Dakan
LICENSE NO. E-605

FIRM NAME: Dakan Funeral Chapel, Cald., Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 12 1969
NOV 13 1969
NOV 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4690
Local Reg. No. 9
Reg. Dist. No. 520-521

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 415 South Ritter 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft
d. STREET ADDRESS (If rural, give location): 415 South Ritter

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Christian Call

4. DATE OF DEATH (Month) (Day) (Year): October 3, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 24, 1887
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): store owner-retired 22
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Chesterfield, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ira Call — BIRTHPLACE: Bountiful, Utah
14. MOTHER'S MAIDEN NAME: Emma J. Barlow — BIRTHPLACE: Bountiful, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-14-4208
17. INFORMANT'S OWN SIGNATURE: Myrna Teuscher — ADDRESS: Bancroft, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-12, 1969, *to* 10-3, 1969, *that I last saw the deceased alive on* 9/29, 1969 *and that death occurred at* 8A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Allen H. Tigert M.D. 534
23b. ADDRESS: Soda Springs, Idaho
23c. DATE SIGNED: 10/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/7/69
24c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery
24d. LOCATION (City, town, or county) (State): Chesterfield, Idaho

DATE REC'D BY LOCAL REG.: 10-18-69
REGISTRAR'S SIGNATURE: Norene Bunn
25. EMBALMER: Theodore S. Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 23 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4691
Local Reg. No. 2041
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

BIRTH NO. 69-9227 RECEIVED

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Cassia (61) OCT 31 1969
b. CITY OR TOWN Burley
c. LENGTH OF STAY (In this place) 12 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka (340)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
d. STREET ADDRESS (If rural, give location) North 3rd St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Brian	Joe (070)	Bingham	Sept. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	White	Never Married	Sept. 6, 1969	-	-	-	12	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant (02)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Burley, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Laroy Joe Bingham, BIRTHPLACE Heyburn, Idaho
14. MOTHER'S MAIDEN NAME Teressa Drussel, BIRTHPLACE Rupert, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Laroy Joe Bingham ADDRESS North 3rd E Paul Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7777

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-6-, 1969, *to* 9-7, 1969, *that I last saw the deceased alive on* 9-7-, 1969, *and that death occurred at* 8½ *Am., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Samuel J. Hammond, MD (647)	Box 47 Paul Idaho	9/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 9, 1969	Riverside Cemetery	Heyburn, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30 1969	Beth A. Pearson	Vern B. McCulloch	E-260

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4692
Local Reg. No. 2034
Reg. Dist. No. 470

BIRTH NO.

RECEIVED OCT 20 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Cassia 16
b. CITY OR TOWN (If outside corporate limits write RURAL and give township): Burley
c. LENGTH OF STAY (In this place): 8 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burley Nursing Home 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elba
d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Don	J.	Whitaker	October 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Married	Nov. 29, 1887	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer of	Agriculture	Almo, Idaho	USA

13. FATHER'S NAME / BIRTHPLACE	14. MOTHER'S MAIDEN NAME / BIRTHPLACE
John N. Whitaker - Willard, Utah	Sarah J. Mallory, Willard, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
no	519-18-0670	Florence W Whitaker Elba Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Generalized Senile — 794X — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Debility & Degeneration

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	none	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
none		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
none m.		

22. *I hereby certify that I attended the deceased from* Oct, 68, *to* Oct 2, 1969, *that I last saw the deceased alive on* D.O.A., 19, *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R Sutton MD	Burley Idaho	10-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/6/69	Elba	Elba Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 17 1969	Bert A. Pearson	Garth Payne	E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 9 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
RECEIVED OF IDAHO

State File No. 4693
Local Reg. No. 2032
Reg. Dist. No. 470

BIRTH NO.

OCT 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Cassia 161	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley c. LENGTH OF (If not in place): days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070	d. STREET ADDRESS (If rural, give location): 1729 Miller Ave.

3. NAME OF DECEASED (Type or Print)	a. (First): Ivan	b. (Middle): LeRoy	c. (Last): Frost	4. DATE OF DEATH (Month) (Day) (Year): Oct. 3, 1969
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Dec. 6, 1892	9. AGE (In years last birthday): 76 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06	10b. KIND OF BUSINESS OR INDUSTRY: *******	11. BIRTHPLACE (State or foreign country): Garfield County, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Stephen Frost	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Sena (Unknown)	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none	16. SOCIAL SECURITY NO.: 519-01-6741A	17. INFORMANT'S OWN SIGNATURE: Mary Smith	ADDRESS: Burley, Ida.	

4409

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Generalized Arteriosclerosis, c̄ Cardiac Arrhythmia (A V Block

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Pneumonia
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1966, *to* 10-3, 1969, *that I last saw the deceased alive on* 10-2, 1969, *and that death occurred at* 10:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. R. Petersen 709 (Degree or title)	23b. ADDRESS: Burley, Idaho	23c. DATE SIGNED: 10-9-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): burial	24b. DATE: 10/6/69	24c. NAME OF CEMETERY OR CREMATORY: Declo Cemetery	24d. LOCATION (City, town, or county) (State): Declo, Idaho
DATE REC'D BY LOCAL REG.: Oct. 13 1969	REGISTRAR'S SIGNATURE: Beth H. Pearson	25. EMBALMER: [signature]	LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4694
Local Reg. No. 2040
Reg. Dist. No. 470

BIRTH NO.

OCT 3 1 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (In this place): 11 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Romney Apts. 1501 Miller Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): Romney Apts. 1501 Miller Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Eda
b. (Middle):
c. (Last): Bohm

4. DATE OF DEATH (Month) (Day) (Year): Oct. 4, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: March 16, 1890

9. AGE (In years last birthday): 79
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Nurse 13

10b. KIND OF BUSINESS OR INDUSTRY: Medical

11. BIRTHPLACE (State or foreign country): Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: August Bohm
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Theresa Troike
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 359-26-6583

17. INFORMANT'S OWN SIGNATURE: Hannah Bohm
ADDRESS: Burley, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease with hypertension due to arteriosclerosis
DUE TO (c): generalized.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-18-69, 19__, to 10-4-69, 19__, that I last saw the deceased alive on 10-2-69, 19__, and that death occurred at ?m., from the causes and on the date stated above. Patient was found dead and had rigor mortis when she was examined by me.

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Snow Bldg. Burley, Idaho
23c. DATE SIGNED: 10-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Oct. 30 1969
REGISTRAR'S SIGNATURE: Beth A. Pearson
25. EMBALMER: Jerry K. Lawson
LICENSE NO.: E-522
FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

APR 2 1970

SEP 2 3 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4695
Local Reg. No. 2033
Reg. Dist. No. 470

RECEIVED OCT 15 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 160 Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Oakley rural
c. LENGTH OF STAY (in this place) Lifetime
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1½ Miles West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Oakley rural
d. STREET ADDRESS (If rural, give location) 1½ Miles West

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Raymond c. (Last) Gee

4. DATE OF DEATH (Month) Oct. (Day) 6, (Year) 1969

5. SEX male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH April 4, 1916

9. AGE (In years last birthday) 53 IF UNDER 1 YEAR Months 6 Days 2 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ranch Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Oakley, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE Lysander Parley Gee, Tooele, Utah

14. MOTHER'S MAIDEN NAME BIRTHPLACE Clara Lewis Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - -

16. SOCIAL SECURITY NO. 518-24-4622

17. INFORMANT'S OWN SIGNATURE Cleo Gee ADDRESS Box 162 Oakley Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrown from horse apparent suffication — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Comm. Feed Lot

21c. (CITY, TOWN, OR TOWNSHIP) Rural (COUNTY) Cassia 3160 (STATE) Idaho

21d. TIME OF INJURY (Month) 10 (Day) 6 (Year) 1969 (Hour) abt. 2:30 pm

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Thrown from horse

22. I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Coroner 583 4

23b. ADDRESS Burley, Idaho

23c. DATE SIGNED 9-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Oct. 10, 1969

24c. NAME OF CEMETERY OR CREMATORY Oakley Cemetery

24d. LOCATION (City, town, or county) Oakley, (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 13 1969

REGISTRAR'S SIGNATURE Ruth A. Pearson

25. EMBALMER Ormand F Burch

LICENSE NO. E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 20 1969

AUG 21 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4696
Local Reg. No. 2036
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 20 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 31 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley rural
d. STREET ADDRESS (If rural, give location): 350 East 300 South

3. NAME OF DECEASED (Type or Print)
a. (First): Dorothy
b. (Middle): Ruth
c. (Last): Bingham

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 28, 1917
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months 9, Days 9 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Yale, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob Uhrich — BIRTHPLACE: Russia
14. MOTHER'S MAIDEN NAME: Anna Marie Lesser, — BIRTHPLACE: Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: 518-44-6190
17. INFORMANT'S OWN SIGNATURE: Gal L. Bingham — ADDRESS: ROUTE #3 BURLEY, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Toxemia Carcinoma of Rt Breast — INTERVAL BETWEEN ONSET AND DEATH: July 1968

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) B Metastases
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July '68
19b. MAJOR FINDINGS OF OPERATION: Duct cell carcinoma of right breast
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-14-51 *19*__, *to* 10-7-69, *19*__, *that I last saw the deceased alive on* 10-7-69, *19*__, *and that death occurred at* 9:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 526
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 10-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Oct. 11, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Oct 17 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Armand F Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 21 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4697
Local Reg. No. 2042
Reg. Dist. No. 470

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

OCT 31 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 161 Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF (If outside corporate limits, write RURAL and give township) 17 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 2728 Almo Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) Floyd
b. (Middle) Owen
c. (Last) Ewer

4. DATE OF DEATH (Month) Oct. (Day) 7, (Year) 1969

5. SEX male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb.24,1920
9. AGE (In years last birthday) 49 — IF UNDER 1 YEAR Months 7 Days 13 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Logan, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Ewer — BIRTHPLACE Logan, Utah
14. MOTHER'S MAIDEN NAME Amy Williams — BIRTHPLACE Mound Valley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War II 4
16. SOCIAL SECURITY NO. 529-10-1200
17. INFORMANT'S OWN SIGNATURE Millie D. Ewer — ADDRESS

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute occlusion right coronary artery — INTERVAL BETWEEN ONSET AND DEATH 24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Recent occlusion left coronary artery with massive septal infarction — 2½ -3 wks
DUE TO (c) Arteriosclerotic cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-13-65, *19*___, *to* 10-7-69, *19*___, *that I last saw the deceased alive on* 10-7-69, *19*___, *and that death occurred at* 11:15 *P.m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 012 (Degree or title)
23b. ADDRESS Snow Bldg. Burley, Idaho
23c. DATE SIGNED 10-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Oct.11,1969
24c. NAME OF CEMETERY OR CREMATORY Logan City Cemetery
24d. LOCATION (City, town, or county) Logan, (State) Utah

DATE REC'D BY LOCAL REG. Oct 30, 1969
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER Ormand F. Burch
LICENSE NO. E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 31 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. ~~NOV 4 1969~~

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 24 1969

Bureau of Vital Statistics

State File No. 4698
Local Reg. No. 2039
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CASSIA (16)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BURLEY
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital (070)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: UTAH (45)
b. COUNTY: SALT LAKE (55)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SANDY
d. STREET ADDRESS (If rural, give location): 1225 WAYSIDE DRIVE

3. NAME OF DECEASED (Type or Print): a. (First) MARJORIE b. (Middle) WILMA c. (Last) ROSE

4. DATE OF DEATH: (Month) OCTOBER (Day) 10, (Year) 1969

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: JANUARY 3, 1923

9. AGE (In years last birthday): 46
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CHARLESTON, WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: ROY MARTIN
BIRTHPLACE: W.VIRGINIA

14. MOTHER'S MAIDEN NAME: ESTELLE MARTIN
BIRTHPLACE: W. VIRGINIA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 8199

17. INFORMANT'S OWN SIGNATURE: x Herbert A. Rose
ADDRESS: Sandy, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute respiratory obstruction — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chest injury, rib fractures with hemothorax — 8 days
DUE TO (c) auto accident — 8 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-6-69

19b. MAJOR FINDINGS OF OPERATION: Tracheostomy only

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): street

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13164 Cassia Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10 2 69 p. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? auto accident

22. *I hereby certify that I attended the deceased from* 10-6, 1969, *to* 10-10, 1969, *that I last saw the deceased alive on* 10-10, 1969, *and that death occurred at* 2 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Leslie L Fillmore (Degree or title) MD 165

23b. ADDRESS: Box 657 Burley Ida

23c. DATE SIGNED: 10-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL-Removal 3

24b. DATE: OCT. 14, 1969

24c. NAME OF CEMETERY OR CREMATORY: CLOVERDALE

24d. LOCATION (City, town, or county) (State): BOISE IDAHO

DATE REC'D BY LOCAL REG.: Oct. 23 1969

REGISTRAR'S SIGNATURE: Burt A. Pearson

25. EMBALMER: Jerry K. Larson

LICENSE NO.: E 522

FIRM NAME: Payne Mortuary - Burley

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4699
Local Reg. No. 2037
Reg. Dist. No. 470

RECEIVED OCT 20 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 16'
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burlay
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CASSIA MEMORIAL HOSPITAL (DOA) 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: T.Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 292 Sunny View Cts.

3. NAME OF DECEASED (Type or Print)
a. (First): MAUDE
b. (Middle):
c. (Last): GARDNER

4. DATE OF DEATH (Month) (Day) (Year): October 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: January 17, 1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Farnam, Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Carmichael — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Ida Squires — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-12-5320
17. INFORMANT'S OWN SIGNATURE: Burley, Idaho — ADDRESS

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic heart disease — 5 years +
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Osteoarthritis — 10 years+

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25, 1966, *to* 10/11/, 1969, *that I last saw the deceased alive on* 10-6, 1969, *and that death occurred at* 11:05 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James H. Spafford +89 M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 18
24b. DATE: 10/15/69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 17 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: James C. Reynolds — LICENSE NO.: E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 21 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

Certificate of Death

STATE OF IDAHO

State File No. 4700
Local Reg. No. 2038
Reg. Dist. No. 470

RECEIVED
OCT 24 1969
Bureau of Vital

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1333 Miller Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Lucina b. (Middle) Sessions c. (Last) Smith

4. DATE OF DEATH: (Month) October (Day) 11 (Year) 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: September 12, 1880
9. AGE (In years last birthday): 89
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse 13
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Woodruff, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harvey Sessions BIRTHPLACE: Bountiful, Utah
14. MOTHER'S MAIDEN NAME: Alice Bryson BIRTHPLACE: Bountiful, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-60-8461
17. INFORMANT'S OWN SIGNATURE: Ruth S. Lyons ADDRESS: Burley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction 4409 — INTERVAL BETWEEN ONSET AND DEATH: 10 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 6 October 1969
19b. MAJOR FINDINGS OF OPERATION: Gall Bladder Disease (Empyema + Hydrops)
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-24-47, 19__, *to* 10-11-69, 19__, *that I last saw the deceased alive on* 10-11-69, 19__, *and that death occurred at* 10:50 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 526 (Degree or title) MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Marion Cem.
24d. LOCATION (City, town, or county) (State): Oakley, Idaho

DATE REC'D BY LOCAL REG.: Oct. 20 1969
REGISTRAR'S SIGNATURE: Ruth N. Pearson
25. EMBALMER: Jerry K. Lawson LICENSE NO.: E-522
FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 13 1969 Bureau of Vital Statistics

State File No. 4701
Local Reg. No. 2044
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (In this place) 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 070 Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) 400 S 350 W

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) C c. (Last) Knight
4. DATE OF DEATH (Month) (Day) (Year) October 15, 1969
5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH August 5, 1881
9. AGE (In years last birthday) 88 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY housework
11. BIRTHPLACE (State or foreign country) Goodwin, S. Dakota
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Deitrich Bremer BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Mary Anna Mahnke BIRTHPLACE Wisconsin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) * *
16. SOCIAL SECURITY NO. 542-32-5048-B
17. INFORMANT'S OWN SIGNATURE Edith Armacost ADDRESS Heyburn, Idah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: few days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarction — 2 wks
DUE TO (c) Arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 4, 1969, to Oct 15, 1969, *that I last saw the deceased alive on* 10-15-69, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)
23b. ADDRESS Burley Idaho
23c. DATE SIGNED 11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE Oct. 15, 69
24c. NAME OF CEMETERY OR CREMATORY Mt. View Mausoleum
24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 19 1969
REGISTRAR'S SIGNATURE Buck H. Pearson
25. EMBALMER Jerry K Payne
LICENSE NO. E-522
FIRM NAME Payne Mortuary-Burley

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4702
Local Reg. No. 2045
Reg. Dist. No. 470

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia (01)
b. CITY OR TOWN: Burley
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give township)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia (01)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Declo
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Carl	Walter	Bunn		Oct.	29	, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	White	Divorced	July 8, 1903	66	3	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (07)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Basin, Cassia Co., Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Joseph Bunn,
BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Elizabeth Sanford,
BIRTHPLACE: Deep Creek, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO. 518-12,6937
17. INFORMANT'S OWN SIGNATURE: Eugene E Bunn
ADDRESS: 452 Canyon Rd Ogden

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7468

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive posterior myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4-5 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congenital stenosis of the osteum to the right coronary artery associated with an annular arteriosclerotic process

DUE TO (c) about the same.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pericarditis, fibrinous acute, severe. 4-5 weeks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 4-8-49, 19___, *to* 10-26-69, 19___, *that I last saw the deceased alive on* 10-26-69, 19___, *and that death occurred at* 12:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] (D12)	Snow Bldg. Burley, Idaho	10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 29, 1969	Declo Cemetery	Declo, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 31 1969	Ruth A. Pearson	Ormand J Burch	E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4703
Local Reg. No. 59
Reg. Dist. No. 210

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clearwater OCT 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (In this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	EVADNA	E.	GANTZ	October	2	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	July 20, 1902	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis Henderson	Oregon	Myrta McFarland	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	N/A		Christine Plaunde	Records Orofino, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1621 Bilateral lobar pneumonia, recurrent — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cancer of the lungs — 3 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility — Several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 16, 1969, *to* October 2, 1969, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 7:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. A. Cleto M.D.	Box 672, Orofino, Idaho	October 2, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-2-69 (9-2-69) error	Walker Funeral Home	McCall Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-2-69	Lern M. Burger	Lyle C. Strothmann	476

FIRM NAME: Walker's Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4704
Local Reg. No. 61
Reg. Dist. No. 210

RECEIVED OCT 20 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): DAVE
b. (Middle): a/k/a Walter Thieman
c. (Last): SCHULSTORF

4. DATE OF DEATH (Month) (Day) (Year): October 8, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: November 5, 1902

9. AGE (In years last birthday): 66
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm, sawmill

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alex Thiman
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-10-5281

17. INFORMANT'S SIGNATURE: Records Christine Plourde
ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchogenic carcinoma of right lung — 6 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 1, 19 69, *to* October 8 19 69, *that I last saw the deceased alive on* October 8, 19 69, *and that death occurred at* 2:25 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. T. Camgoz, M.D. (Degree or Title)

23b. ADDRESS: Box 672, Orofino, Idaho

23c. DATE SIGNED: Oct. 10, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Oct. 13, 69

24c. NAME OF CEMETERY OR CREMATORY: Riverside

24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: 10-16-69

REGISTRAR'S SIGNATURE: Lern M. Burger

25. EMBALMER: Lydia Stutzman
LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 20 1969

Certificate of Death

STATE OF IDAHO

State File No. 4705
Local Reg. No. 62
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater (180)
b. CITY OR TOWN Orofino
c. LENGTH OF STAY (in this place) 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Clearwater Valley Hosp. (073)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner (090)
c. CITY OR TOWN Idaho Hill
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alice	Clarissa	Falk	Oct. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married	Mar. 20, 1878	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife (61)	own home	Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Zachriah T. Jackson	Ohio,	Mary E. Sandborn	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	536-07-4300	Lyle A. Shortman	Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractured left femur
DUE TO (c) Osteoporosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

8877X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE / (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) SHN 13	21c. (CITY, TOWN, OR TOWNSHIP) 13180 (COUNTY) (STATE) Orofino Clearwater Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
9-17-69 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fall

22. *I hereby certify that I attended the deceased from* 9-27, 1969, *to* 9-11, 1969, *that I last saw the deceased alive on* 9-11, 1969, *and that death occurred at* 1:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert D Hall, (440) MD	Orofino, Idaho	10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	10-15-69	Blanchard Cemetery	Blanchard, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-16-69	Vern M. Burger	Lyle A. Shortman	476

FIRM NAME: SHERMAN FUNERAL HOMES, INC.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

SEP 1 4 2005

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4706
Local Reg. No. 64
Reg. Dist. No. 210

RECEIVED STATE OF IDAHO

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 180 Clearwater NOV 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (in this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 101 Miller Street

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) c. (Last) FRANK

4. DATE OF DEATH (Month) (Day) (Year) October 23, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH August 4, 1892

9. AGE (In years last birthday) 77
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-62-2834

17. INFORMANT'S OWN SIGNATURE Christine Plaude Records
ADDRESS Orofino, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

153.1

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-pulmonary complications — INTERVAL BETWEEN ONSET AND DEATH: 15 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cancer of digestive tract-large intestine — Unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis and senility — Several years

19a. DATE OF OPERATION 9/6/69 and 9/18/69

19b. MAJOR FINDINGS OF OPERATION Colonic obstruction; adenocarcinoma splenic flexure of colon

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 3, 19 69, *to* October 23 19 69, *that I last saw the deceased alive on* October 23, 19 69, *and that death occurred at* 12:38 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 595 Carlos Fernandez-Ledon (Degree or title) M.D.

23b. ADDRESS Box 672, Orofino, Idaho

23c. DATE SIGNED October 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Oct. 24, 69

24c. NAME OF CEMETERY OR CREMATORY English Funeral Home

24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. Oct. 28, 1969

REGISTRAR'S SIGNATURE Lern M. Burger

25. EMBALMER

LICENSE NO. 476

FIRM NAME: ENGLISH FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4707
Local Reg. No. 65
Reg. Dist. No. 210

BIRTH NO.

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater (180)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. (073)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater (180)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe-rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): LOWELL
b. (Middle): T.
c. (Last): HANSEN

4. DATE OF DEATH (Month) (Day) (Year): Oct. 23, 1969

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 7, 1921

9. AGE (In years last birthday): 48
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic (21)

10b. KIND OF BUSINESS OR INDUSTRY: auto repair

11. BIRTHPLACE (State or foreign country): St. Andrew, Wn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hans C. Hansen
BIRTHPLACE: Unk.

14. MOTHER'S MAIDEN NAME: Unk.
BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 535-12-0671

17. INFORMANT'S OWN SIGNATURE: X Evelyn Hansen
ADDRESS: Weippe

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage. (2509)
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Diabetes mellitus
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct. 21, 1969, *to* Oct 23, 1969, *that I last saw the deceased alive on* Oct. 23, 1969, *and that death occurred at* 7:43A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert D. Hall M.D.
23b. ADDRESS: Route 3, Orofino, Idaho
23c. DATE SIGNED: 10/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Oct. 28, 1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Oct. 31, 1969
REGISTRAR'S SIGNATURE: Lura M. Burger
25. EMBALMER: Lyle R. Strottmann
LICENSE NO.: 476

FIRM NAME: Gilbert's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 9 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 21 2013

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4708
Local Reg. No. 67
Reg. Dist. No. 210

Certificate of Death

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 7 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 510 Foster

3. NAME OF DECEASED (Type or Print)
a. (First): ASHLEY
b. (Middle): B.
c. (Last): CASE

4. DATE OF DEATH (Month) (Day) (Year): October 27, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: December 11, 1885
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired tailor 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Case — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): N/A
16. SOCIAL SECURITY NO.: 519-36-2907
17. INFORMANT'S OWN SIGNATURE Records — ADDRESS: Christine Plowde, Orofino, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*
(a) Posterior myocardial rupture — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Recent myocardial infarction — 1 week
DUE TO (c) Advanced generalized arterio-sclerosis and senility — Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 5, 1969, *to* October 22, 1969, *that I last saw the deceased alive on* October 22, 1969, *and that death occurred at* 6:30 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE C. A. Cleto, M.D. (Degree or title): 595 Constancio A. Cleto M.D.
23b. ADDRESS: Box 672, Orofino, Idaho
23c. DATE SIGNED: Oct. 29, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Oct. 29, 69
24c. NAME OF CEMETERY OR CREMATORY: English Funeral Home
24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct. 31, 1969
REGISTRAR'S SIGNATURE: Lern M. Burger
25. EMBALMER: Fyl A. Strothmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FORM NAME: English Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 11 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4709
Local Reg. No. 68
Reg. Dist. No. 210

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater (180)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino-rural
c. LENGTH OF STAY in this place min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lower Fords Cr. area (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater (180)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location) Johnson Tr. Ct.

3. NAME OF DECEASED (Type or Print) a. (First) WAYNE b. (Middle) LEROY c. (Last) KESSLER

4. DATE OF DEATH (Month) (Day) (Year) Oct. 29, 1969

5. SEX M

6. COLOR OR RACE Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH June 21, 1942

9. AGE (In years last birthday) 27
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) woods work 17

10b. KIND OF BUSINESS OR INDUSTRY lumber

11. BIRTHPLACE (State or foreign country) Orofino, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Donald Kessler
BIRTHPLACE Unk.

14. MOTHER'S MAIDEN NAME Aluma Corbet
BIRTHPLACE Idaho
Ahsahka

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 518-50-1896

17. INFORMANT'S OWN SIGNATURE X Amelia Koske
ADDRESS Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9229

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ruptured left pulmonary vein
INTERVAL BETWEEN ONSET AND DEATH: sec.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) gunshot wound
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) woods 31
21c. (CITY, TOWN, OR TOWNSHIP) 1318C (COUNTY) (STATE) Orofino, Clearwater, Orofino, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 29, 69 - 5:00 p.m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? shot when mistaken for a deer

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) .583 4 Coroner
23b. ADDRESS Route 1, Orofino, Idaho
23c. DATE SIGNED 11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 3, 69
24c. NAME OF CEMETERY OR CREMATORY Ahsahka
24d. LOCATION (City, town, or county) (State) Ahsahka, Idaho

DATE REC'D BY LOCAL REG. Nov. 6, 1969
REGISTRAR'S SIGNATURE Vern M. Burger
25. EMBALMER Lyle A. Stillmann
LICENSE NO. 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended November 3, 1969

Certificate of Death
STATE OF IDAHO

State File No. 4710
Local Reg. No. 9
Reg. Dist. No. 680

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Custer 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Morgan Creek 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Ohio 36
b. COUNTY: Geuga 535
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burton
d. STREET ADDRESS (If rural, give location): Route 700

3. NAME OF DECEASED (Type or Print): a. (First) Allen; b. (Middle) Richard; c. (Last) Schliecker

4. DATE OF DEATH (Month) (Day) (Year): October 4, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Dec 2, 1956

9. AGE (In years last birthday): 12
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cleveland, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Schliecker
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Beulah Mae Conley
BIRTHPLACE: W. Va.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT'S OWN SIGNATURE: Kenneth R. Conley
ADDRESS: Cleveland, Ohio

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9229

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Gunshot wound head
INTERVAL BETWEEN ONSET AND DEATH: -0-

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Hunting trip 31
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Morgan Creek 13190 Custer Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): October 4, 1969 3p m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Accidental discharge of gun

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ralph Potter, Coroner, Custer Co. 365 4
23b. ADDRESS: Challis, Idaho
23c. DATE SIGNED: 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial 3
24b. DATE: 10-5-69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest
24d. LOCATION (City, town, or county) (State): Bedford, Ohio

DATE REC'D BY LOCAL REG.: 10-7-69
REGISTRAR'S SIGNATURE: Pauline J. Mulder
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369

FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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10-17-69

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
OCT 27 1969
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death) for Allen Richard Schecker (Name on Original Certificate) who died (Was Born or Died) on Oct. 4, 1969 (Date of Event) in Challis, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 3c Last name	Schecker	Schliecker
Item 13	Schecker	Schliecker

Subscribed and sworn to before me this 23 day of October, 19 69

Notary Public, residing at Cleveland, Ohio

My commission expires No Expiration date

(Seal)

Signed Anna Lisa Cowling
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

14227 Niagara Dr. Strongsville, Ohio
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.
County of ..... }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 23 day of October, 19 69

Notary Public, residing at Cleveland, Ohio

My commission expires No Expiration date

(Seal)

Signed Michael W. Cicirette
(Signature of Any Credible Person)

14187 NIAGARA DR., STRONGSVILLE OHIO
(Street Address, City, State)

FORM DH 80-155 5 copies pd Rec. # 23394

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 8 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 9
Reg. Dist. No. 680

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Custer
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Morgan Creek

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Ohio
b. COUNTY: Geuga
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burton
d. STREET ADDRESS (If rural, give location): Route 700

3. NAME OF DECEASED (Type or Print): a. (First) Allen; b. (Middle) Richard; c. (Last) Schecker

4. DATE OF DEATH (Month) (Day) (Year): Oct. 4, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Dec. 2, 1956

9. AGE (In years last birthday): 12
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cleveland, Ohio

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard Schecker
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Beulah Mae Conley
BIRTHPLACE: W.Va.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT'S OWN SIGNATURE: Kenneth R Conley
ADDRESS: Cleveland, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gunshot wound head
INTERVAL BETWEEN ONSET AND DEATH: -0-

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): hunting trip
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Morgan Creek, Custer, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 4, 1969 3 P m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Accidental discharge of gun

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ralph Potter Coroner, Custer Co
23b. ADDRESS: Challis, Idaho
23c. DATE SIGNED: 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial
24b. DATE: 10-5-69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest
24d. LOCATION (City, town, or county) (State): Bedford, Ohio

DATE REC'D BY LOCAL REG.: 10-7-69
REGISTRAR'S SIGNATURE: Pauline J. Mulder
25. EMBALMER: Delbert C Jones
LICENSE NO.: E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4711
Local Reg. No. 68
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200 — OCT 27 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. Elmore Memorial Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13 — b. COUNTY Owyhee 375
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Indian Cove
d. STREET ADDRESS (If rural, give location) Indian Cove

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NATHAN	ABRAHAM	MILLER	Oct. 11 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 17, 1905	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stockman & Farmer 04	Own Farm	Hubbard, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Obed Miller	Indiana	Ella Yoder	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-01-0584	Leanna Miller	Indian Cove, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4419

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Aneurysm Ruputure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Investigation only, 19__, *to* 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur Smith 383	Coroner	Mountain Home, Idaho	10/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/15/69	Glenn Rest Cemetery	Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 20 69	T Anderson	J Verl Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4712
Local Reg. No. 71
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED NOV 20 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Mountain Home
d. STREET ADDRESS (If rural, give location): Rt. # 1, Box 663

3. NAME OF DECEASED (Type or Print): a. (First) MRS. b. (Middle) FERNE c. (Last) OPAL LOTT

4. DATE OF DEATH (Month) (Day) (Year): October 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Dec. 22, 1900	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Fruita, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John T. Beaman	Kansas	Annie Lehman	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-10-5985	Earl Lott	Mtn. Home, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction - Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Thrombosis

DUE TO (c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: (a) 4 days (b) minutes (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 6, 69 *to* Oct. 18, 69, *that I last saw the deceased alive on* Oct. 18, 69, *and that death occurred at* 4:04 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Melvin W. Nelson MD	Mountain Home, Idaho	Nov 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/23/69	Mtn. View Cemetery	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 17 1969	[illegible] Andersen	[illegible] Smith	E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4713
Local Reg. No. 67
Reg. Dist. No. 380 391

BIRTH NO. 69-9296

RECEIVED NOV 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (In this place): see
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Elmore Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 950 No. 3rd East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DAVID	ALLEN	JONES	October 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Sept. 27, 1969			22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mountain Home AFB, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Calvin Jones — BIRTHPLACE: Alabama
14. MOTHER'S MAIDEN NAME: Carolyn McClead — BIRTHPLACE: West Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Michael C. Jones — ADDRESS: Mtn. Home, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7269 Sudden Death Syndrome — INTERVAL BETWEEN ONSET AND DEATH: hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Etiology unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigation only, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith, S3 4 (Degree or title) Coroner
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 10/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 10/20/69
24c. NAME OF CEMETERY OR CREMATORY: Albertville, Alabama
24d. LOCATION (City, town, or county) (State): Albertville, Alabama

DATE REC'D BY LOCAL REG.: Nov 17 1969
REGISTRAR'S SIGNATURE: [illegible] Anderson
25. EMBALMER: Arthur Smith
LICENSE NO.: E-403
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 1 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 19 1969

MAY 28 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4714
Local Reg. No. 69
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED NOV 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 20
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospitail 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: 553
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Monument Valley
d. STREET ADDRESS (If rural, give location): Rural - Monument Valley

3. NAME OF DECEASED (Type or Print): a. (First) TULLY b. (Middle) c. (Last) YAZZIE

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1969

5. SEX: Male

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 21, 1915

9. AGE (In years last birthday): 53
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Kent, Arizona

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 529-20-0029

17. INFORMANT'S OWN SIGNATURE: Elmore Memorial Hosptial Records.
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 890X Acute GI hemorrhage.
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): 95% Body Burn.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Bunkhouse 02
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Bruneau, Owyhee, Idaho 1337
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 20, 1969 5:00 AM
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Victim trapped in burning bunkhouse.

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Howell M. Weeks 623 MD
23b. ADDRESS: 890 W 6th East Mt Home
23c. DATE SIGNED: 11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10/22/69
24c. NAME OF CEMETERY OR CREMATORY: Monument Valley, Utah
24d. LOCATION (City, town, or county) (State): Monument Valley, Utah

DATE REC'D BY LOCAL REG.: Nov 17 1969
REGISTRAR'S SIGNATURE: [illegible]
25. EMBALMER: Arthur Smith
LICENSE NO.: E-403
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 4 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 24 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4715

Local Reg. No.

Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY Elmore 200 OCT 28 1969

b. CITY OR TOWN Glenns Ferry Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 13 b. COUNTY Elmore 200

c. CITY OR TOWN Glenns Ferry

d. FULL NAME OF HOSPITAL OR INSTITUTION 215 East Snakeriver Ave. 000

d. STREET ADDRESS (If rural, give location) 215 East Snake River Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	THEODORE	WINSTON	JOSLYN	Oct. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	Feb. 13, 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Civil Service 05	F.A.A.	Tacoma, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Joslyn	Massachusetts	Mattie I. Sitton	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	544-05-0125	C. W. Joslyn	Glenns Ferry, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did not see alive - investigation only, 19__, *to* 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Arthur Smith SR 4 (Degree or title) Coroner	Mountain Home, Idaho	10/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	10/24/69	Mtn. View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-23-69	Mary Sullivan	Edwd Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

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PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4716
Local Reg. No. 72
Reg. Dist. No. 380 391

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Mem. Nursing Home 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): Elmore Memorial Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLIE
b. (Middle): Y.
c. (Last): WONG

4. DATE OF DEATH (Month) (Day) (Year): October 23, 1969

5. SEX: Male
6. COLOR OR RACE: Chinese
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 5, 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Businessman 22
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Canton, China
12. CITIZEN OF WHAT COUNTRY?: China

13. FATHER'S NAME: Unknown — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-38-4580
17. INFORMANT'S OWN SIGNATURE: X Tom Wong — ADDRESS: Mtn. Home, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

1) Chronic bronchitis of trachea years
2) Acute pneumonitis disease days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 22, 1969, *to* Oct. 23, 1969, *that I last saw the deceased alive* Oct. 22, 1969, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Malone W. Loebch MD (Degree or title) 284
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: November 17 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/27/69
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Nov 17 1969
REGISTRAR'S SIGNATURE: P. Anderson
25. EMBALMER: F. Neil Humphreys
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4717
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

RECEIVED STATE OF IDAHO

NOV 17 1969

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANDREW	JACKSON	KNAPP	October 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Nov. 28, 1892	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railroad	U.P. Rail Road	Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
(NA)		(NA)	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-24-8371	Mrs A. J. Knapp	Glenns Ferry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Chronic emphysema — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Coronary insufficiency — 2 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 7, 1967, *to* Oct 26, 1969, *that I last saw the deceased alive on* Oct 26, 1969, *and that death occurred at* 6:40 *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Wendell Archer M.D. (Degree or title)	Box 70 Glenns Ferry Ida	Nov 13, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 31, 1969	Glenn Rest Cemetery	Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 13 1969	Mary Sullivan	L. Wel Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 1 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to supply the facts shall sign HIS name in addition to giving the source of information.

MAY 19 2011

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

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(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

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STATEMENT OF USUAL RESIDENCE OF DECEASED

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ADDITIONAL REMARKS by Physician.....

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RECEIVED NOV 20 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4718
Local Reg. No. 73
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
d. STREET ADDRESS (If rural, give location): 311 E. Arthur

3. NAME OF DECEASED (Type or Print)
a. (First): WAYNE
b. (Middle): RICHARD
c. (Last): BOSTIC

4. DATE OF DEATH (Month) (Day) (Year): October 31, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: August 29, 1936
9. AGE (In years last birthday): 33 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Station Operator 260
10b. KIND OF BUSINESS OR INDUSTRY: Service Station
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ed Bostic — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Golda Morgan — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-30-0543
17. INFORMANT'S OWN SIGNATURE: + Mrs Wayne Bostic — ADDRESS: Glenns Ferry, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Arrest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): acute diabetes acidosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Troy W. Walker 718 (Degree or title) MD
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 3, 1969
24c. NAME OF CEMETERY OR CREMATORY: Glenn Rest Cemetery
24d. LOCATION (City, town, or county) (State): Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.: Nov 17 1969
REGISTRAR'S SIGNATURE: C. Anderson
25. EMBALMER: H Weil Humphreys
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

DUTIES:

NOV 20 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 4719
Local Reg. No. 70
Reg. Dist. No. 380 391

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore — NOV 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn Home AFB
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 67 Tac Hosp, Mt Home AFB ID

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn Home
d. STREET ADDRESS (If rural, give location): Waters Trailer Court

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Willie	Dea	Hogstrom	October	31	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	CAU	Married	19 September 1919	50				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Ross Benson — BIRTHPLACE: Benson Arkansas
14. MOTHER'S MAIDEN NAME: Annie Brown — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 429-14-3964
17. INFORMANT'S OWN SIGNATURE: + Mrs. Hogstrom — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Breast, Right, Metastatic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 31 October, 1969, *to* 31 October, 1969, *that I last saw the deceased alive on* 31 October, 19 69, *and that death occurred at* 1850 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron E Kolts, CAPT USAF MC MD	Mtn Home AFB, ID	31 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 4, 1969	Mountain View Cemetery	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 5 1969	[signature]	[signature] Smith Mortuary	E-502

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

NOV 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED NOV 20 1969 Bureau of Vital Statistics STATE OF IDAHO

State File No. 4720
Local Reg. No. 74
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Mountain Home
c. LENGTH OF STAY (in this place): 3 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Rest Home 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): King Hill
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Louie	Ball	Patty	Oct. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	June 25, 1881	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	home	Metze, West Virginia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James H. Baker	West Virginia	Permala Rice	West Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	721-14-2110	Silvia I. Heath	Shoshone

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1579

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) anemia
DUE TO (c) Carcenoma of pancreas

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Donna G Bell MD (Degree or title)	Mountain Home, Idaho	11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-4-69	Glenn Rest Cemetery	Glenns Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 17 1969	Anderson	Joe B. Leeper Joe B Leeper	E-530

FIRM NAME: Leeper Mortuary Wendell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 30 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4721
Local Reg. No. 13
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 211 OCT 23 1969
b. CITY OR TOWN Preston
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 211
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 358 North State

3. NAME OF DECEASED (Type or Print)
a. (First) HENRY
b. (Middle) EUGENE
c. (Last) BAIR

4. DATE OF DEATH (Month) (Day) (Year) October 7, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH September 1, 1889

9. AGE (In years last birthday) 80 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)

10b. KIND OF BUSINESS OR INDUSTRY Pet Milk Co.

11. BIRTHPLACE (State or foreign country) Richmond, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William A. Bair
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Lucinda Brower
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 528 05 6698

17. INFORMANT'S OWN SIGNATURE Anna C. Bair
ADDRESS Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) C V A
INTERVAL BETWEEN ONSET AND DEATH 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1, 1969 *to* Oct 7, 1969 *that I last saw the deceased alive on* Oct 4, 1969, *and that death occurred at* 12 M. *m., from the causes and on the date stated above.*

23a. SIGNATURE O. A. Cullen (Degree or title) MD

23b. ADDRESS Preston Idaho

23c. DATE SIGNED 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 10, 1969

24c. NAME OF CEMETERY OR CREMATORY Richmond Cemetery

24d. LOCATION (City, town, or county) Richmond, Utah (State)

DATE REC'D BY LOCAL REG. 10-10-69

REGISTRAR'S SIGNATURE Eyre W. Brower

25. EMBALMER O. Sherwin Webb

LICENSE NO. 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: OCT 27 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4722
Local Reg. No. 14
Reg. Dist. No. 540

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Preston — NOV 4 1969
b. CITY OR TOWN Preston
Bureau of Vital Statistics
LENGTH OF STAY in this place: 8 WKS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) HANNAH
b. (Middle) ELSIE
c. (Last) BURRUP CLEGG

4. DATE OF DEATH (Month) (Day) (Year): 10-18-69

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: January 26, 1890

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Downey, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wm Burrup
BIRTHPLACE: Ogden, Utah

14. MOTHER'S MAIDEN NAME: Hannah M. Byington
BIRTHPLACE: Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 519 05 4731

17. INFORMANT'S OWN SIGNATURE: Donna C. Evans
ADDRESS: Preston, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): C V P — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 15, 1964, *to* Oct 18, 1969 *that I last saw the deceased alive on* Oct 18, 1969, *and that death occurred at* 11 PM m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O R Cutler MD

23b. ADDRESS: Preston Idaho

23c. DATE SIGNED: 10 20 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 21, 1969

24c. NAME OF CEMETERY OR CREMATORY: Downey Cemetery

24d. LOCATION (City, town, or county) (State): Downey, Idaho

DATE REC'D BY LOCAL REG.: 10-21-69

REGISTRAR'S SIGNATURE: Effie M. Brower

25. EMBALMER: Douglas S. Webb

LICENSE NO.: 488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4723
Local Reg. No. 15
Reg. Dist. No. 540

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 211 NOV 4 1969
b. CITY OR TOWN Preston
c. LENGTH OF STAY IN (this place) 72 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION 166 East Oneida

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 211
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 166 East Oneida

3. NAME OF DECEASED (Type or Print)
a. (First) GLADYS
b. (Middle) HALCYON
c. (Last) DAINES SEAMONS

4. DATE OF DEATH (Month) (Day) (Year) Oct. 19, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May 8, 1897
9. AGE (In years last birthday) 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Franklin, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William M. Daines — BIRTHPLACE Hyde Park, Utah
14. MOTHER'S MAIDEN NAME Elizabeth Ann Hatch — BIRTHPLACE Lehi, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 18 2626D
17. INFORMANT'S OWN SIGNATURE Blaine J. Seamons — ADDRESS Ogden, Utah

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Thrombosis — 4 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19, 1969 *to* 10-19, 1969 *that I last saw the deceased alive on* 10-19, 1969, *and that death occurred at* 8 ## m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Preston, Idaho
23c. DATE SIGNED 10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 23, 1969
24c. NAME OF CEMETERY OR CREMATORY Preston Cemetery
24d. LOCATION (City, town, or county) (State) Preston, Idaho

DATE REC'D BY LOCAL REG. 10-23-69
REGISTRAR'S SIGNATURE Eppie W. Brower
25. EMBALMER Douglas S. Webb
LICENSE NO. 488

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4724
Local Reg. No. 37
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 210 — OCT 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Island Park- Rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Near Henrys Lake

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) EDWIN; b. (Middle) ROOSEVELT; c. (Last) DUNLOP

4. DATE OF DEATH: (Month) Oct., (Day) 1, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct., 11, 1908

9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months 11, Days 20 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Poultry Raising 04

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Deming, New Mexica

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Dunlop — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Bashon — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 559-12-4013

17. INFORMANT'S OWN SIGNATURE: Walter E Dunlop — ADDRESS: Macks Inn Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul Powell 583 Coroner

23b. ADDRESS: Box 170 St. Anthony, Ida. 83445

23c. DATE SIGNED: 10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 4 Oct 69

24c. NAME OF CEMETERY OR CREMATORY: Targhee Cemetery

24d. LOCATION (City, town, or county) (State): Henrys Lake, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 10-10-69

REGISTRAR'S SIGNATURE: M. D. Hansen

25. EMBALMER: M. D. Hansen — **LICENSE NO.**: E-354

FIRM NAME: Hansen Memorial Chapel
ria

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4725
Local Reg. No. 43
Reg. Dist. No. 651

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Fremont 220
b. CITY OR TOWN Ashton
c. LENGTH OF STAY in this place 2 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
d. STREET ADDRESS (If rural, give location) none given

3. NAME OF DECEASED (Type or Print): a. (First) Clyde b. (Middle) Edwin c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year): Oct 20, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: May 10, 1888

9. AGE (In years last birthday): 81 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): city employee 08

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Richmond, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hyrum Williams BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Sophia Frandsen BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 519-01-8722

17. INFORMANT'S OWN SIGNATURE: X Mable Stalker ADDRESS: Rexburg, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary atherosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: (a) 2 hours (b) ? (c)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 20, 1969, *to* _____, 19____, *that I last saw the deceased alive on* Oct 20, 1969, *and that death occurred at* 3:45 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 23b. ADDRESS Ashton Idaho 23c. DATE SIGNED 10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Nov 3, 1969 24c. NAME OF CEMETERY OR CREMATORY Pineview Cemetery 24d. LOCATION (City, town, or county) (State) Ashton, Fremont Co., Idaho

DATE RECD BY LOCAL REG. 3 Nov 69 REGISTRAR'S SIGNATURE Mel Hansen 25. EMBALMER Robert Q. Bean LICENSE NO. E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUN 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4726
Local Reg. No. 220
Reg. Dist. No. 651

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony Rural
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 Miles SouthWest of St. Anthony

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): RFD#1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EVA	ARCHIBALD	RICE	Oct., 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Married	August 23, 1901	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher 12	Retired	Rexburgm Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas W. Archibald	Wellsville, Utah	Ellen Ricks	Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-44-1955	Donald C. Rice	St. Anthony, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8129

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Fractured Skull and Internal injuries — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13220 (COUNTY) (STATE)
Accident	County Road 66	St. Anthony, RFD#1, Fremont, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Oct., 25, 1969 3:45PM		Two cars collieded at rural road intersection

22. *I hereby certify that I attended the deceased from* DOA, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 3:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul Romrell SB3 4	Coroner	St. Anthony, Idaho	27 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	29 Oct 69	Rexburg Cemetery	Rexburg, RFD, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
27 Oct 69	M. D. Hansen	M. D. Hansen	E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 6 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 3 0 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206:

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4727
Local Reg. No. 42
Reg. Dist. No. 650

Certificate of Death

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 221
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): 31 West 6th South

3. NAME OF DECEASED (Type or Print)
a. (First): ANNA
b. (Middle): STRONG
c. (Last): RUMSEY

4. DATE OF DEATH (Month) (Day) (Year): Oct 29, 1969

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowe
8. DATE OF BIRTH: 14 Oct 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Stewart, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Strong — BIRTHPLACE: Savanah, Georgia
14. MOTHER'S MAIDEN NAME: Effie Prouty — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-58-2067
17. INFORMANT'S OWN SIGNATURE: James Rumsey — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2399

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Peritoneitis - acute — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Gastric haemorrhage — 1 hr.
DUE TO (c): undetermined

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Abdominal tumor

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 28, 1969, *to* Oct 29, 1969, *that I last saw the deceased alive on* Oct 29, 1969, *and that death occurred at* 8:30 *pm., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. S. Soule MD 488
23b. ADDRESS: St. Anthony, Idaho
23c. DATE SIGNED: 31 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1 Nov 69
24c. NAME OF CEMETERY OR CREMATORY: Wilford Cemetery
24d. LOCATION (City, town, or county) (State): St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.: 31 Oct 69
REGISTRAR'S SIGNATURE: M. D. Hansen
25. EMBALMER: M. D. Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Stat

State File No. 4728
Local Reg. No. 31
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 230 OCT 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 8 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rolling Hills Orchard

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Rt. 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ersal	Leland	Pope	Oct. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	June 29, 1912	57	3	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Resident-manager 04	orchard	Basalt, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter L. Pope	Oakley, Idaho	Mabel E. Davis	Wilford, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-10-0867	Dal L. Pope	

9288X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) accidental drowning due to farm machinery accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13230 (COUNTY)	(STATE)
accident	Orchard 02	Emmett, Gem	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Oct. 4 69 3.30 P.m.		tractor operated by deceased backed into canal

22. I hereby certify that I attended the deceased from Never, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 3:30P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clifford Perry 583 Justice of the Peace & Ex Officio Coroner	805 E. 3rd Emmett, Ida	Oct. 6, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 8, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 6, 1969	Jean A Beatty	Walter Potter	E445

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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R.

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4729
Local Reg. No. 22
Reg. Dist. No. 3[illegible]

BIRTH NO.

NOV 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Gem 231	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett; c. LENGTH OF DAY (In this place) 3 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085	d. STREET ADDRESS (If rural, give location) 410 East 5th

3. NAME OF DECEASED (Type or Print) a. (First) Frances	b. (Middle)	c. (Last) Kreizenbeck	4. DATE OF DEATH (Month) (Day) (Year) Oct. 13, 1969		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 31, 1897	9. AGE (In years last birthday) 72	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Menominee, Michigan	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Guay	BIRTHPLACE unknown	14. MOTHER'S MAIDEN NAME Della Rosa Brusaw	BIRTHPLACE unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-12-0876	17. INFORMANT'S OWN SIGNATURE [signature]	ADDRESS		

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 24, 1968, *to* October 13, 1969, *that I last saw the deceased alive on* Oct 12, 1969, *and that death occurred at* 4:20A *m., from the causes and on the date stated above.*

23a. SIGNATURE Wm B. Jewell MD. 260 (Degree or title)	23b. ADDRESS 1024 E Locust, Emmett, Ida	23c. DATE SIGNED 10-15-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Oct. 15, 1969	24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Oct 28, 1969	REGISTRAR'S SIGNATURE [signature]	25. EMBALMER [signature]	LICENSE NO. E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4730
Local Reg. No. 23
Reg. Dist. No. 340-34 1

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Gem 23 — NOV 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gem 23
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Rt. 2, Box 159

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ova	Martin	Evans	Oct. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Oct. 15, 1898	71	0 / 13	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer	farm	Penokee, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Tom Evans	Missouri	Mary McDowell	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-2450A	X Ralph M Evans	Rt 2

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c). 4319

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-1 *19* 54 *, to* 10-28 *, 19* 69 *, that I last saw the deceased alive on* 10-28 *, 19* 69 *, and that death occurred at* 9:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harman E. Halverson M.D.	Emmett, Idaho	11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 31, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Juan A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4731
Local Reg. No. 3174
Reg. Dist. No. 420

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 13 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding (rural)
c. LENGTH OF TIME (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 16 mi. No. on Hwy #46 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 932 North Eisenhower

3. NAME OF DECEASED (Type or Print)
a. (First): EVERETT
b. (Middle): EDWARD
c. (Last): MAIN

4. DATE OF DEATH (Month) (Day) (Year): Oct. 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 1, 1926
9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Announcer 23
10b. KIND OF BUSINESS OR INDUSTRY: Radio
11. BIRTHPLACE (State or foreign country): Salem, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward J. Main — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Mellissa M. Gunter — BIRTHPLACE: No. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. II 4
16. SOCIAL SECURITY NO.: 518 30 3469
17. INFORMANT'S OWN SIGNATURE: X Mrs. Patricia Main — ADDRESS: Jerome, Ida.

8169

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Head injuries — INTERVAL BETWEEN ONSET AND DEATH: 2 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): car wreck
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 16-miles North 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Gooding 13-240 Gooding Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 3, 1969 3:00 AM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: One car roll over-auto accident

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* Approx 3A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard E. Hunt 553 4 Coroner
23b. ADDRESS: Gooding Idaho
23c. DATE SIGNED: 7 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Oct. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: 10-9-1969
REGISTRAR'S SIGNATURE: Eddie G. Leach
25. EMBALMER: W. L. Hoag
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4732
Local Reg. No. 3175
Reg. Dist. No. 420

Certificate of Death

RECEIVED
OCT 24 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho T.B. & Chest Dis. Hosp 091

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1005 19th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Ruth
b. (Middle): —
c. (Last): Wright

4. DATE OF DEATH (Month) (Day) (Year): 10-15-69

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 4-28-93
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Villa Grove, Colorado
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. M. Pitzer — BIRTHPLACE: Clark Co. Ill
14. MOTHER'S MAIDEN NAME: Eliz. Jane Doherty — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Hosp. Records / K.A. Tyler M.D. — ADDRESS: T.B. Hosp.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease c̄ Coronary — INTERVAL BETWEEN ONSET AND DEATH: mos?

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Thrombosis of left Pul. Vessels — weeks?
DUE TO (c) Terminal Pneumonia

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* old mod. adv. Pul. Tbc. "open sig." 30 yrs ±

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9, 1969, *to* 10-15, 1969, *that I last saw the deceased alive on* 10-14, 1969 *and that death occurred at* 8:30 *am., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K.A. Tyler 598 M.D.
23b. ADDRESS: Idaho T.B. Hosp. Gooding
23c. DATE SIGNED: Oct. 15, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal - Burial
24b. DATE: October 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Lewiston Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston Nez Perce Co. Idaho

DATE REC'D BY LOCAL REG.: Oct. 17, 1969
REGISTRAR'S SIGNATURE: Eddie G. Leach
25. EMBALMER: Eddie G. Leach
LICENSE NO.: E-511

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: THOMPSON CHAPEL - GOODING, IDA.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 28 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4733
Local Reg. No. 3176
Reg. Dist. No. 420

Certificate of Death

RECEIVED
OCT 24 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. Statistics OF STAY (in this place): 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho T.B. & Chest Disease Hosp 091

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): Box 626

3. NAME OF DECEASED (Type or Print)
a. (First): Everett
b. (Middle): R
c. (Last): Dugan

4. DATE OF DEATH (Month) (Day) (Year): 10 - 20 - 69

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widower
8. DATE OF BIRTH: 10-16-1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer & miner 07
10b. KIND OF BUSINESS OR INDUSTRY: mines
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Dugan — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Hester Brown — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 519-28-7478A
17. INFORMANT'S OWN SIGNATURE: Hosp. records — ADDRESS: 1 K.A. Tyler M.D.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*	(a) Bronchial obstructive Lung Disease	? yrs
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*	DUE TO (b) Silico-Tuberculosis	1 yr. +
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-22, 1969, *to* 10-20, 1969, *that I last saw the deceased alive on* 10-20, 1969, *and that death occurred at* 8:50 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K.A. Tyler M.D. 598
23b. ADDRESS: Gooding, Idaho T.B. & Chest Dis. Hosp
23c. DATE SIGNED: 10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 10-23-1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 10-22-1969
REGISTRAR'S SIGNATURE: Eddie G. Leach
25. EMBALMER: Edgar J. Robertson
LICENSE NO.: E-507
FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4734
Local Reg. No. 3178
Reg. Dist. No. 420

BIRTH NO.

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN: Wendell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 413 East Ave. "E"

3. NAME OF DECEASED (Type or Print)
a. (First): JESSIE
b. (Middle): GERTRUDE
c. (Last): RAVER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 22, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 8, 1878

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Walton, Indiana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Chappelear
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Elizabeth Minnick
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 07 2291

17. INFORMANT'S OWN SIGNATURE: X Mrs. Mae M. Schee
ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular accident
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-19-67, 19X, *to* Oct. 22, 1969, *that I last saw the deceased alive on* Oct 21, 1969, *and that death occurred at* 1:20P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Mrs. Mae M. Schee MD
23b. ADDRESS: Wendell, Idaho
23c. DATE SIGNED: 10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: Oct. 28, 1969
REGISTRAR'S SIGNATURE: Eddie G. Leach
25. EMBALMER: W. S. Hove
LICENSE NO.: E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4735
Local Reg. No. 3
Reg. Dist. No. 420

BIRTH NO.

RECEIVED STATE OF IDAHO
Bureau of Vital Statistics
NOV 4 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN Gooding
c. LENGTH OF STAY (In this place) 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho T.B. & Chest Disease Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendal
d. STREET ADDRESS (If rural, give location) 446 3rd Ave East

3. NAME OF DECEASED (Type or Print) a. (First) Ralph b. (Middle) m c. (Last) Black

4. DATE OF DEATH (Month) (Day) (Year) 10-23-69

5. SEX M

6. COLOR OR RACE Cauc

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH 6-2-1894

9. AGE (In years last birthday) 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & hard rock miner

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Forkston Calif

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Ralph Black — BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Emily Countryman — BIRTHPLACE Gridley Calif

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. 518-16-0734

17. INFORMANT'S OWN SIGNATURE Douglas O Smith M.D. — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

0190

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Obst pulmonary disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Moderately-advanced Silicotuberculosis (years)
DUE TO (c) (inactive)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ASHD - Cardiac decompensation (10 yrs)

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* 10-23, 1969, *that I last saw the deceased alive on* 10-22, 1969, *and that death occurred at* 6:27 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Douglas O Smith M.D.

23b. ADDRESS 134 W 4th and Gooding

23c. DATE SIGNED 10-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-27-69

24c. NAME OF CEMETERY OR CREMATORY Challis Cemetery

24d. LOCATION (City, town, or county) (State) Challis, Idaho

DATE REC'D BY LOCAL REG. 10-27-1969

REGISTRAR'S SIGNATURE Eddie Leach

25. EMBALMER Joe B. Leeper — LICENSE NO. E-530

FIRM NAME: Leeper Mortuary — Wendell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-630-21

DUTIES:

NOV 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 16 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4736
Local Reg. No. 3179
Reg. Dist. No. 420

BIRTH NO.

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri 26
b. COUNTY: Lafayette 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Willington
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILFORD	IRA	CLAY	October 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	April 11, 1924	45				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Apple Rancher	Apples	Greenville, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew Clay	Unk.	Myrtle Searcy	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		+ Loretta Clay	Willington, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 12:50P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard Thurston MD	Gooding Idaho	11-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 28, 1969	Hagerman Cemetery	Hagerman, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30, 1969	Edna C. Leach	Joe B. Leeper	E-530

FIRM NAME: Leeper Mortuary Wendell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4737
Local Reg. No. 21
Reg. Dist. No. 242

BIRTH NO.

RECEIVED
OCT 31 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY in this place: 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Marys Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
d. STREET ADDRESS (If rural, give location): Cottonwood

3. NAME OF DECEASED (Type or Print): a. (First) KATHERINE b. (Middle) ELIZABETH c. (Last) AIBERS

4. DATE OF DEATH: (Month) Oct. (Day) 6, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 11 1894

9. AGE (In years last birthday): 75 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Melrose, Minnesota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Melchior Wensman — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Agnes Weichman — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 536 30 9238

17. INFORMANT'S OWN SIGNATURE: X Mrs W J Zimmer — ADDRESS: Spokane, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2000

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Reticulum cell sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 2-3 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): generalized.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: A.S.H.D.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 18, 1969, *to* Oct. 6, 1969, *that I last saw the deceased alive on* Oct 6, 1969, *and that death occurred at* 3:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard E Orr M D 348

23b. ADDRESS

23c. DATE SIGNED: 10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/9/1969

24c. NAME OF CEMETERY OR CREMATORY: Cottonwood Cathloic Cem.

24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: Oct. 22 '69

REGISTRAR'S SIGNATURE: Elizabeth H. Uhlorn

25. EMBALMER: Robert B Hansen — LICENSE NO.: E433

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DEC 5 1969
JUN 22 1971

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4738
Local Reg. No.
Reg. Dist. No.

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 15 1969

Bureau of Vital

1. PLACE OF DEATH
a. COUNTY 252 Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah
c. LENGTH OF STAY (in this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2 miles South of Kamiah 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah
d. STREET ADDRESS (If rural, give location) 2 miles South of Kamiah

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) R.
c. (Last) MC PHEETERS

4. DATE OF DEATH (Month) (Day) (Year) October 9, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH April 14, 1897
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk 25
10b. KIND OF BUSINESS OR INDUSTRY Grange Store
11. BIRTHPLACE (State or foreign country) Oreana, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William H McPheeters — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Mattie Whalon — BIRTHPLACE Columbus, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW # 1 & 2 4
16. SOCIAL SECURITY NO. 518 05 6128
17. INFORMANT'S OWN SIGNATURE Wayne S Mashuets — ADDRESS Kamiah, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5192

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: few Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Cor Pulmonale — few hours
DUE TO (c) Chronic Obstructive Lung Disease — 15-20 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-18, 1968 *to* 9-10, 1969, *that I last saw the deceased alive on* 9-10, 1969, *and that death occurred at* 5:30 pm, *from the causes and on the date stated above.*

23a. SIGNATURE 652 [signature] (Degree or title)
23b. ADDRESS Kamiah, Idaho
23c. DATE SIGNED 10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/14/1969
24c. NAME OF CEMETERY OR CREMATORY Kamiah
24d. LOCATION (City, town, or county) (State) Kamiah, Idaho

DATE REC'D BY LOCAL REG. 10-13-69
REGISTRAR'S SIGNATURE Viola V. Paul dep
25. EMBALMER Robert R Hansen — Robert R Hansen
LICENSE NO. E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED
OCT 27 1969
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4739
Local Reg. No. 66
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hosp 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 604 N College

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): N.M.N
c. (Last): BAUNE

4. DATE OF DEATH (Month) (Day) (Year): October 13, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 4, 1891
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Lawrence, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Baune — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Theresa Grichler — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 42 0490
17. INFORMANT'S OWN SIGNATURE: Leo Baune NH — ADDRESS: Grangeville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Oct., 1954, *to* Oct. 13, 1969, *that I last saw the deceased alive on* Oct. 13, 1969, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 444 (Degree or title): [signature] MD
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: Oct. 18, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/16/1969
24c. NAME OF CEMETERY OR CREMATORY: Cottonwood Catholic
24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: Oct. 21, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433
FIRM NAME: Hansen Funeral home

Federal Security Agency
United States Public Health Service
Form DH-63021

FEB 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 13 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4740
Local Reg. No. 68
Reg. Dist. No. 240

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

NOV 5 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1306 South Hall 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 1306 South Hall

3. NAME OF DECEASED (Type or Print)
a. (First): BLANCHE
b. (Middle): BEATRICE
c. (Last): HOWARD

4. DATE OF DEATH (Month) (Day) (Year): October 14, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 12, 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Meadows, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter White — BIRTHPLACE: Horseshoe, Bend, Idaho
14. MOTHER'S MAIDEN NAME: Nellie Smith — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 03 5410 B
17. INFORMANT'S OWN SIGNATURE: Frank Howard — ADDRESS: Grangeville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) probable acute ventricular arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis — sev. years,
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* about, 1947, *to* 14 oct, 1969, *that I last saw the deceased alive on* 13 oct, 1969, *and that death occurred at* 3:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald Veltman M.D. 487
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 27 oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 10/16/69
24c. NAME OF CEMETERY OR CREMATORY: Mt. View
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Oct. 31, 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 13 1970

OCT 19 2016

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4741
Local Reg. No. 22
Reg. Dist. No. 242

RECEIVED
OCT 31 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Idaho 25
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood,
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	J.	Jentges	October 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed	May 30, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	stock & Grain	Granville, Iowa	U S

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John P. Jentges		unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518 05 2804 A	John F. Seubert	Cottonwood, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4379 Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Mar. 26, 1969, *to* Oct. 13, 1969, *that I last saw the deceased alive on* Oct. 13, 1969, *and that death occurred at* 1:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard E Orr 348 MD	Cottonwood, Ida	10/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 18 1969	Catholic	Greencreek, Idaho Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Oct 22 '69	Elizabeth H. Uhlorn	Custer Uhlorn EHDI.	Cottonwood Idaho

Uhlorn Funeral Home.

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

FEB 6 1970

APR 2 1975

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4742
Local Reg. No.
Reg. Dist. No.

RECEIVED
OCT 31 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 25
b. CITY OR TOWN: Cottonwood
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Marys Hospital 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 25
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) ALOYSIUS b. (Middle) JOSEPH c. (Last) WAGNER

4. DATE OF DEATH: (Month) October (Day) 16, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 3, 1901

9. AGE (In years last birthday): 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Theater Owner 22

10b. KIND OF BUSINESS OR INDUSTRY: Movie

11. BIRTHPLACE (State or foreign country): Harvey North Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Wagner
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Helen Meisch
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 36 4587

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

342X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Atelectasis — 2 weeks
DUE TO (c): Parkinsons Disease — 27 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Sept, 1966, *to* Oct. 16, 1969, *that I last saw the deceased alive on* Oct. 16, 1969, *and that death occurred at* 9:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD (Degree or title)
23b. ADDRESS: Grangeville Idaho
23c. DATE SIGNED: Oct. 21, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 18, 1969
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: Elizabeth Uhlorn

25. EMBALMER: Robert R Hanson [signature]
LICENSE NO.: E 433
FIRM NAME: Hanson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: OCT 3 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4743
Local Reg. No. 65
Reg. Dist. No. 240

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 252 OCT 27 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Highway #95 4 miles West
STAY (in this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Riggins
d. STREET ADDRESS (If rural, give location) Riggins, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) JACK b. (Middle) W c. (Last) ROBERTS

4. DATE OF DEATH (Month) (Day) (Year) October 18, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH April 14, 1900

9. AGE (In years last birthday) 69
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ranch Hand 07

10b. KIND OF BUSINESS OR INDUSTRY Farming & live stock

11. BIRTHPLACE (State or foreign country) Waha, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alex Roberts
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Bertha Craig
BIRTHPLACE West Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 24 3671

17. INFORMANT'S OWN SIGNATURE Joe Roberts
ADDRESS Kooskia, Idaho

8129

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushing Injuries to Chest and Body
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) Highway # 95 06
21c. (CITY, TOWN, OR TOWNSHIP) Grangeville 13250 (COUNTY) Idaho (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 18, 1969 6:30 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Head On Car Wreck

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 583 IDAHO COUNTY CORONER
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 22, 1969
24c. NAME OF CEMETERY OR CREMATORY Prairieview
24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Oct 20, 1969
REGISTRAR'S SIGNATURE Irma Cone

25. EMBALMER Robert R Hansen Robert R Hansen
LICENSE NO. E 433
FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4744
Local Reg. No. 77
Reg. Dist. No. 240

BIRTH NO.

RECEIVED NOV 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Idaho 25
b. CITY OR TOWN Grangeville
LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Grangeville General Hosp 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Oregon 38
b. COUNTY Harney 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Crane
d. STREET ADDRESS (If rural, give location) Crane, Oregon

3. NAME OF DECEASED (Type or Print) a. (First) ARLIE b. (Middle) R c. (Last) BLACK

4. DATE OF DEATH (Month) (Day) (Year) October 21, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH
9. AGE (In years last birthday) X 36 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 07
10b. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Rye Valley, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ray Black BIRTHPLACE Warren County, Illinois
14. MOTHER'S MAIDEN NAME Alta Justin BIRTHPLACE Rye Valley, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean 6
16. SOCIAL SECURITY NO. 8199 Yes.
17. INFORMANT'S OWN SIGNATURE X Ray Black ADDRESS Crane, Oregon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Head and Chest injuries, Massive
INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) U.S. Hwy 95 06
21c. (CITY, TOWN, OR TOWNSHIP) 3252 (COUNTY) Idaho (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Automobile accident

22. *I hereby certify that I attended the deceased from* 10/19, 1969, *to* 10/21, 1969, *that I last saw the deceased alive on* 10/21, 1969, *and that death occurred at* 5:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE 373 (Degree or title) MD
23b. ADDRESS Grangeville, Id.
23c. DATE SIGNED 11/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Oct 21, 1969
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. Nov. 14 1969
REGISTRAR'S SIGNATURE Hema Cone
25. EMBALMER Robert R Hansen Robert R Hansen
LICENSE NO. E 433
FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 16 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4745
Local Reg. No. 69
Reg. Dist. No. 240

RECEIVED
Bureau of Vital Statistics
NOV 4 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 252
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lowell
c. LENGTH OF STAY (In this place): Minutes

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nezperce 251
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3420 6th

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 16 Miles East on Deadmans Creek 000

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	FRANKLIN	MIESEN	October 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	July 31, 1934	35				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tour Foreman Pulp & Paper 26
10b. KIND OF BUSINESS OR INDUSTRY: P.F.I.
11. BIRTHPLACE (State or foreign country): St Maries, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Larrabee Ruskin Miesen — BIRTHPLACE: Joplin, Mo.
14. MOTHER'S MAIDEN NAME: Violet Jean Meader — BIRTHPLACE: Kalispell, Mont

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519 36 8579
17. INFORMANT'S OWN SIGNATURE: George L. Miesen — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9229

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Gun Shot Wound of Abdomen — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Undetermined
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 31
21c. (CITY, TOWN, OR TOWNSHIP): East Of Lowell — (COUNTY): Idaho 23250 — (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 25 69 11AM
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Hunting Fatality

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] — (Degree or title): 583 IDAHO COUNTY CORONER
23b. ADDRESS:
23c. DATE SIGNED: 10-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 10/28/69
24c. NAME OF CEMETERY OR CREMATORY: St Maries Cemetery
24d. LOCATION (City, town, or county) (State): St Maries, Idaho

DATE REC'D BY LOCAL REG.: Oct 30 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen
LICENSE NO.: E 433
FIRM NAME: Brower-Wonn Lewiston

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

69-10405 RECEIVED NOV 14 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4746
Local Reg. No. 24
Reg. Dist. No. 242

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cottonwood
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Greencreek,
d. STREET ADDRESS (If rural, give location) rural

3. NAME OF DECEASED (Type or Print) a. (First) Mark b. (Middle) c. (Last) Wassmuth

4. DATE OF DEATH (Month) (Day) (Year) October 26 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH October 26, 1969

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 1 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cottonwood, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Virgil Wassmuth BIRTHPLACE Greencreek, Idaho

14. MOTHER'S MAIDEN NAME Donna Duman BIRTHPLACE Cottonwood, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Virgil R Wassmuth ADDRESS Greencreek, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Extreme Prematurity 7691 — INTERVAL BETWEEN ONSET AND DEATH 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Premature delivery 29 wks (mother) — 1 hr.

DUE TO (c) Premature rupture membranes (mother)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 26, 19 69, *to* Oct 26, 19 69, *that I last saw the deceased alive on* Oct 26, 19 69, *and that death occurred at* 01:20 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) William H Greenwood, MD 189

23b. ADDRESS Grangeville Idaho

23c. DATE SIGNED 11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 27 1969

24c. NAME OF CEMETERY OR CREMATORY Greencreek Catholic

24d. LOCATION (City, town, or county) Greencreek Idaho (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 7 '69

REGISTRAR'S SIGNATURE Elizabeth H. Wilborn

25. FUNERAL DIRECTOR Elizabeth H. Wilborn FD39 Wilborn Funeral Home

ADDRESS Cottonwood, Idaho

Federal Security Agency
United States Public Health Service

Form DPH-40021

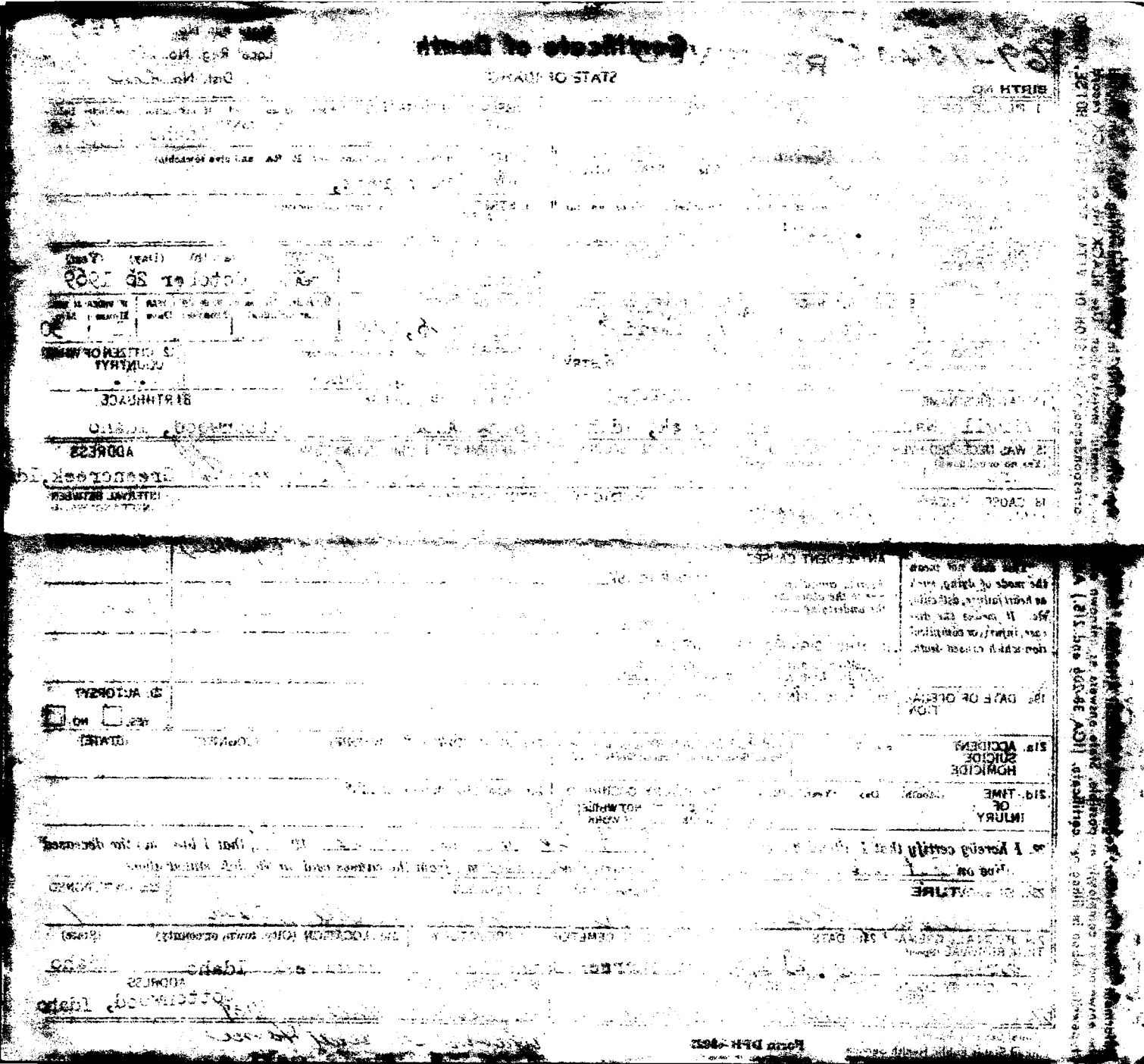

State File No. 4747
Local Reg. No. 27
Reg. Dist. No. 242

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nezperce
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Lena
b. (Middle):
c. (Last): Miller

4. DATE OF DEATH (Month) (Day) (Year): Oct 27 69

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Aug 30 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): St. James, Nebraska
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Charles Brocke — BIRTHPLACE: St. James Nebraska
14. MOTHER'S MAIDEN NAME: Katherine Burgel — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: W 518 42 2346
17. INFORMANT'S OWN SIGNATURE: X Jack B. Miller — ADDRESS: Nezperce

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) accident, strabo.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1969, *to* Oct. 27, 1969, *that I last saw the deceased alive on* Oct. 27, 1969, *and that death occurred at* 3:02A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 398 [signature] MD
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: Oct. 29, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Nov 30 69
24c. NAME OF CEMETERY OR CREMATORY: Community
24d. LOCATION (City, town, or county) (State): Nezperce, Idaho

DATE REC'D BY LOCAL REG.: Nov. 10, 1969
REGISTRAR'S SIGNATURE: Elizabeth K. Uhlorn
25. FUNERAL DIRECTOR: Clifford Uhlorn — ADDRESS: Cottonwood, Idaho
Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

20. AUTOPSY?
Yes ☐ No ☒

State File No. 4748
Local Reg. No. 25
Reg. Dist. No. 242

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NOV 14 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 1 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkhill Manor Nursing Home 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood, Idaho
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Joseph
b. (Middle):
c. (Last): Hoffman

4. DATE OF DEATH (Month) Oct (Day) 30 (Year) 69

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 15 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Cattle
11. BIRTHPLACE (State or foreign country): St. Jo Texas
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Joseph Hoffman — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Ellen Bailey — BIRTHPLACE: Mississippi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 463 12 1916
17. INFORMANT'S OWN SIGNATURE: X Zelda Hoffman — ADDRESS: Cottonwood Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Emphysema — 10 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: aortic abdominal aneurism — Several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1969, *to* Oct 30, 1969, *that I last saw the deceased alive on* Oct 28, 1969, *and that death occurred at* 3:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William H. Greenwood, MD 189
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 1 1969
24c. NAME OF CEMETERY OR CREMATORY: Catholic
24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: Nov. 7, 1969
REGISTRAR'S SIGNATURE: Elizabeth H. Uhlorn
25. FUNERAL DIRECTOR: Curtis Uhlorn — ADDRESS: Cottonwood Idaho
Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

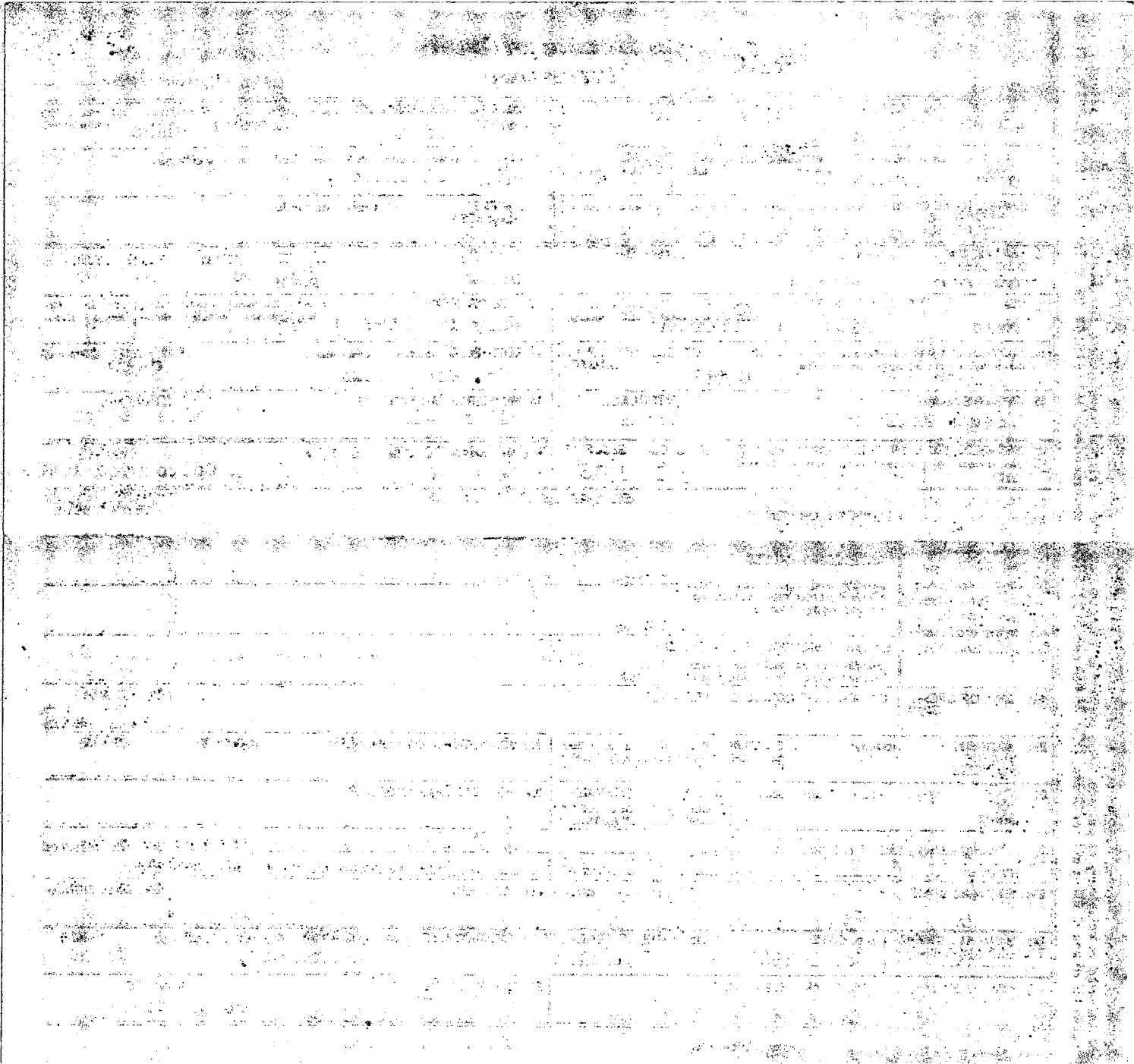

Certificate of Death

STATE OF IDAHO

State File No. 4749
Local Reg. No. 38
Reg. Dist. No. 342

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cottonwood
LENGTH OF STAY (in this place) 1 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cottonwood
d. STREET ADDRESS (If rural, give location) rural

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Frank	J.	Riener		Oct	30	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Oct 8 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain
11. BIRTHPLACE (State or foreign country) Herndon, Nebraska
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME Paul J. Riener
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Mary Walters
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 40 8098 A
17. INFORMANT'S OWN SIGNATURE Mary A. Riener
ADDRESS Cottonwood, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ASH Disease Auth — INTERVAL BETWEEN ONSET AND DEATH 6 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac decompensation
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* November, 1968, *to* Oct. 30, 1969, *that I last saw the deceased alive on* Oct. 30, 1969, *and that death occurred at* 8:58 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
398 E C Orr M D	Cottonwood, Idaho	Nov. 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 1 1969	Catholic	Greencreek, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Nov. 10, 1969	Elizabeth H. Uhlorn	Uhlorn Funeral Home E491.	Cottonwood, Idaho

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

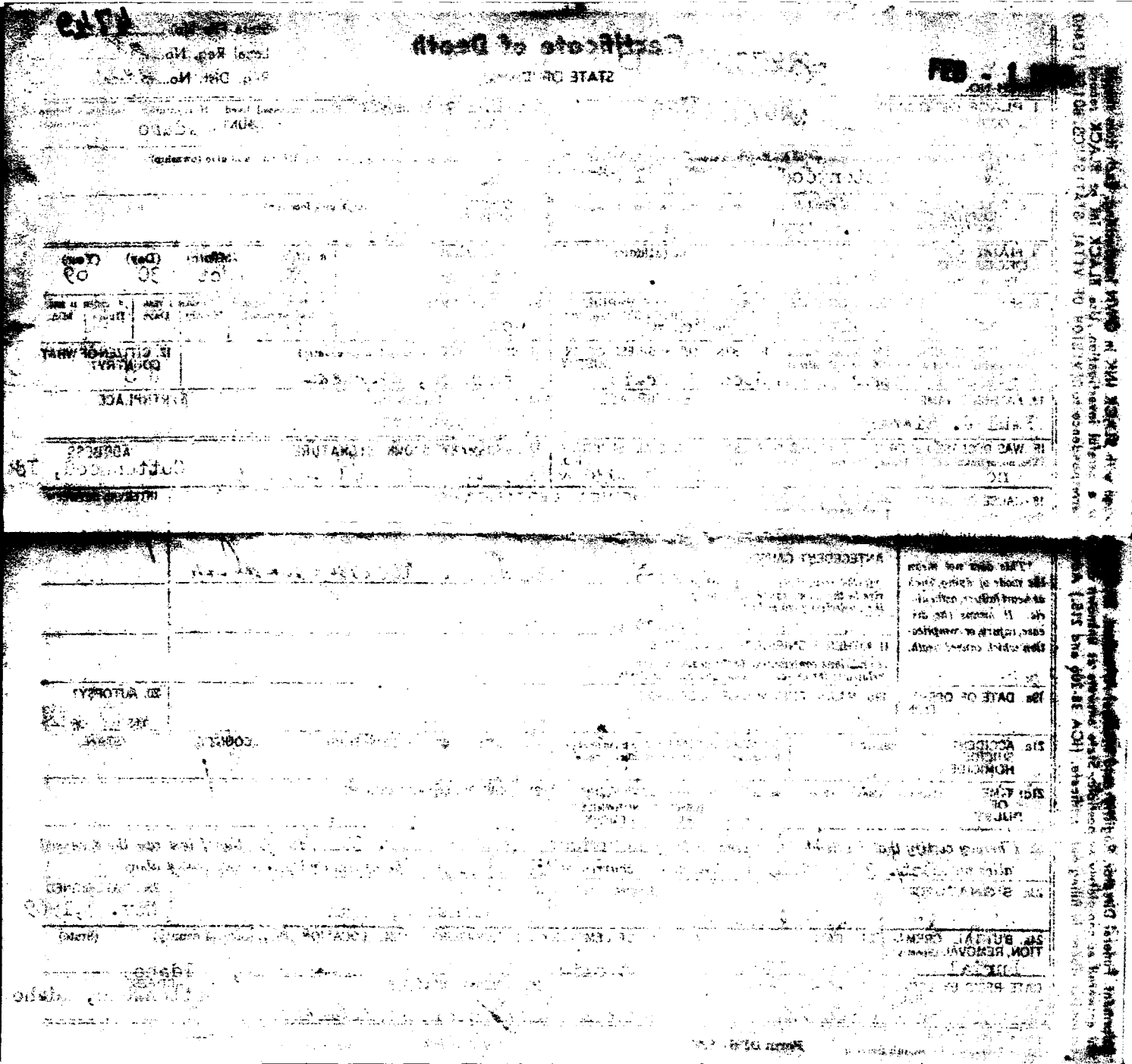

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4750
Local Reg. No. 26
Reg. Dist. No. 342

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
LENGTH OF STAY (in this place) 1½ yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkhill Manor 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cottonwood
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Alma b. (Middle) c. (Last) Buettner

4. DATE OF DEATH (Month) (Day) (Year) October 31 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Dec. 18, 1873	96				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	New Holstein, Wisconsin	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Holdenried	Germany	Anchen Blase	Teinsville, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519 30 8663B	X Roland Buettner	Cottonwood, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	chronic ulcers of age	indef.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

794X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* October, 1968, *to* October 31, 1969, *that I last saw the deceased alive on* Oct 30, 1969, *and that death occurred at* 11:45 Am., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John Morrison 373	MD	Grangeville, Ida.	Nov 5 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 3 1969	Cottonwood Community	Cottonwood, Idaho, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Nov. 7, 1969	Elizabeth A. Wilson	Elizabeth N. Wilson FD 39 Wilson Funeral Home	Cottonwood, Idaho

Federal Security Agency
United States Public Health Service

Form DPH-48021

Certificate of Death

NOV 20 1969

STATE OF IDAHO

BURIAL NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4751
Local Reg. No. 16
Reg. Dist. No. 640

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hamer (rural)
LENGTH OF STAY (in this place): min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7 miles North of Hamer 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: Orange 355
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Santa Anna
d. STREET ADDRESS (If rural, give location): 2013 W. 10th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALLEN		DORSCHT	Sept. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Apr. 6, 1944	25				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Extruder 06	Plastic	Petrolia Ontario Canada	Canada

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clarence Dorscht	(not available)	Olga	(not available)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No None	547-88-8015	Hazel M. Abrigo	2013 W 10th Santa Anna, Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull Fracture — INTERVAL BETWEEN ONSET AND DEATH: Inst.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 1326 (COUNTY) (STATE)
Accident	Street 04	Hamer Jefferson Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Sept. 27, 1969 11 P	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Driver of automobile lost control of auto. Rolled over

22. *I hereby certify that* ~~XXXX

DUTIES:

NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4752
Local Reg. No. 07
Reg. Dist. No. 640

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Menan
c. LENGTH OF STAY (In this place): One Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Deerpark 5 Mi. Northwest Menan

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Menan
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ole	———	Hansen	September 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	October 29, 1889	79	11	0		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Norway	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peder Hansen	Norway	Karen Johanna Olaveson	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WWI 3	518-05-9321	David O. Hansen	509 E St. Idaho Falls, Idah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that* I attended the deceased from [illegible] to [illegible], that I last saw the deceased alive on [illegible], and that death occurred at 7:40 P. m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Norman Hall 583	Coroner	Rigby Idaho	10/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 2, 1969	Annis Cedar Butte Cemetery	Annis Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10/21/1969	Mrs A B Eckwall	Leo A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 4 1969
JUL 8 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended November 18, 1969

Certificate of Death
STATE OF IDAHO

State File No. 4753
Local Reg. No. 1255
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Benedicts Hospital 049

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 83316
d. STREET ADDRESS (If rural, give location): 909 Sprague Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Gertrude; b. (Middle) V.; c. (Last) Farlinger

4. DATE OF DEATH: (Month) October (Day) 6, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: August 13, 1892

9. AGE (In years last birthday): 77
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Eustis, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Methven
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Clara Lehman
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-40-9279

17. INFORMANT'S OWN SIGNATURE: Mrs. A. G. Biswell
ADDRESS: Dietrich, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive heart failure
INTERVAL BETWEEN ONSET AND DEATH: 2½ weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 27, 19 69, *to* October 6, 19 69, *that I last saw the deceased alive on* October 6, 19 69, *and that death occurred at* 7:00 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Jon D. Wilmoth, M.D. 770 (Degree or title)
23b. ADDRESS: 216 E. Main, Jerome, Idaho
23c. DATE SIGNED: Oct 9, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Oct 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Buhl Cemetery
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: Oct 15, 1969
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: George Farmer
LICENSE NO.: E 480

FIRM NAME: Albertson-Dickard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

Affidavit to Correct or Amend an Original Certificate of Birth or Death

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Gertrude V. Farlinger (Name on Original Certificate) who died (Was Born or Died) on October 4, 1969 (Date of Event)
in Jerome, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#4 Date of Death	October 4, 1969	October 6, 1969
#22 time attended	from August 27, 1969 to October 4, 1969	from August 27, 1969 to October 6, 1969

Subscribed and sworn to before me this 14th day of November, 1969

Notary Public, residing at Shoshone, Idaho

My commission expires 5 May 1972

(Seal)

Signed Jo D Wilmoth MD
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

216 East Main; Jerome, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.
County of ..... }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this ..... day of ....., 19.....

Notary Public, residing at .....

My commission expires .....
(Seal)

Signed .....
(Signature of Any Credible Person)

.....
(Street Address, City, State)

FORM DH 60-155

2-11-12-69

Certificate of Death

RECEIVED STATE OF IDAHO

OCT 17 1969

Bureau of Vital Statistics

State File No.
Local Reg. No. 1255
Reg. Dist. No. 440

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 83316
d. STREET ADDRESS (If rural, give location): 909 Sprague Ave

3. NAME OF DECEASED (Type or Print): a. (First) GERTRUDE b. (Middle) V. c. (Last) FARLINGER

4. DATE OF DEATH (Month) OCT (Day) 4 (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: August 13, 1892

9. AGE (In years last birthday): 77
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Eustis, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Methven
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Clara Lehman
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-40-9279

17. INFORMANT'S OWN SIGNATURE: Mrs A. G. Bissell Dietrick
ADDRESS: Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive heart failure
INTERVAL BETWEEN ONSET AND DEATH: 2½ weeks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 27, 1969, to October 4, 1969, that I last saw the deceased alive on October 4, 1969, and that death occurred at 7:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE: Jon A. Wilmoth, M.D. (Degree or title)

23b. ADDRESS: 214 E. Main; Jerome, Idaho

23c. DATE SIGNED: Oct. 9, 1969.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct 9, 1969

24c. NAME OF CEMETERY OR CREMATORY: Buhl Cemetery

24d. LOCATION (City, town, or county) (State): Buhl Idaho

DATE REC'D BY LOCAL REG.: Oct. 15, 1969

REGISTRAR'S SIGNATURE: Louella M. Scherer

25. EMBALMER: George Farmer

LICENSE NO.: E-480

FIRM NAME: Albertson-Dickard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 18 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 14 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4754
Local Reg. No. 1254
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 513 East Ave. "H"

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLOTTE	JANE	GRIFFITH	Oct. 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Feb. 28, 1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Oakley, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
H. R. Matthews	Utah	Sarah Ann Williams	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 10 7513	X Jack Griffith	Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1719 Liposarcoma c

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) metastases to lungs
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 7 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
March 1969	Liposarcoma	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 1969 *to* Oct 5, 1969, *that I last saw the deceased alive on* Oct 5, 1969, *and that death occurred at* 3:45A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. G. Moss MD	Jerome Ida	10/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 9, 1969	Oakley, Cemetery	Oakley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
October 9 1969	M. Dene Overfield	W. L. Hove	E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4755
Local Reg. No. 1256
Reg. Dist. No. 440

Certificate of Death

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): Woolley Apartments

3. NAME OF DECEASED (Type or Print)
a. (First): ELBERT
b. (Middle):
c. (Last): DRUMILER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 11, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 15, 1913
9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper 19
10b. KIND OF BUSINESS OR INDUSTRY: Auto Agency
11. BIRTHPLACE (State or foreign country): Ogden, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Elbert P. Drumiler — BIRTHPLACE: Nevada
14. MOTHER'S MAIDEN NAME: Nettie Shaw — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 529 03 8073
17. INFORMANT'S OWN SIGNATURE: Daniel W. Drumiler — ADDRESS: Bountiful, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

398X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Rheumatic heart disease with pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: Many years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Asthma, emphysema, hypertension — Years

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 1963, 19__, *to* Oct 11, 1969, *that I last saw the deceased alive on* Oct 11, 1969, *and that death occurred at* 1:35P *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. Carlyle Smail — (Degree or title): MD
23b. ADDRESS: Jerome, Idaho
23c. DATE SIGNED: 10/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Oct. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Aultorest Cemetery
24d. LOCATION (City, town, or county) (State): Ogden, Utah

DATE REC'D BY LOCAL REG.: Oct. 15, 1969
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4756
Local Reg. No. 1258
Reg. Dist. No. 440

BIRTH NO.

RECEIVED
OCT 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY JEROME 270	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eden c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eden 83325
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchar d St.	d. STREET ADDRESS (If rural, give location) Orchard St.

3. NAME OF DECEASED (Type or Print)	a. (First) JAMES	b. (Middle) MARK	c. (Last) SKELTON	4. DATE OF DEATH (Month) (Day) (Year) October 12, 1969	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 8, 1891	9. AGE (In years last birthday) 78	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker 27	10b. KIND OF BUSINESS OR INDUSTRY Trucking	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Richard R. Skelton	BIRTHPLACE unknown	14. MOTHER'S MAIDEN NAME unknown	BIRTHPLACE unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) ----	16. SOCIAL SECURITY NO. 519-05-8633	17. INFORMANT'S OWN SIGNATURE Sylvia Skelton	ADDRESS Eden, Idaho	

4122

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hypertensive arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 16, 1966, *to* Oct 12, 1969, *that I last saw the deceased alive on* Oct 7, 1969 *and that death occurred at* 7 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 460 (Degree or title)	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 10-14-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/15/1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho
DATE REC'D BY LOCAL REG. Oct. 20 1969	REGISTRAR'S SIGNATURE Louella M. Scherer	25. EMBALMER Edgar J. Robertson	LICENSE NO. E-507

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 25 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4757
Local Reg. No. 1257
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 20 1969 Bureau

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): N.S.Canal Co. Coulee near 6th. Ave. West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton 83335
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): DWIGHT
b. (Middle): SENEBER
c. (Last): BROOKS

4. DATE OF DEATH (Month) (Day) (Year): Oct. 13, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Oct. 18, 1906
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Bean Warehouse
11. BIRTHPLACE (State or foreign country): Craigmont, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Seneber S. Brooks — BIRTHPLACE: Oregon
14. MOTHER'S MAIDEN NAME: Alwilda Forgey — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 557 09 9254
17. INFORMANT'S OWN SIGNATURE: X W. K. Fine — ADDRESS: Hazelton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Secondary to Barbiturate
DUE TO (c): Medication —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Irrigation ditch
21c. (CITY, TOWN, OR TOWNSHIP) 13270 (COUNTY) (STATE): 18 Jerome Jerome Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Fell into open ditch

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* approx. 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. M. Leher, M.D. Coroner 583 4
23b. ADDRESS: Jerome
23c. DATE SIGNED: 16 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hazelton Cemetery
24d. LOCATION (City, town, or county) (State): Hazelton, Idaho

DATE REC'D BY LOCAL REG.: Oct. 16, 1969
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

DUTIES:

OCT 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 30 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4758
Local Reg. No. 1263
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict Long Care Unit 357

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): St. Benedict Long Care Unit

3. NAME OF DECEASED (Type or Print)
a. (First): ANNA
b. (Middle): E.
c. (Last): RIDLEY

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 3, 1891
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months 7, Days 15 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Rollins County, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Koski — BIRTHPLACE: Poland
14. MOTHER'S MAIDEN NAME: Elizabeth — BIRTHPLACE: Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-22-7902-A
17. INFORMANT'S OWN SIGNATURE: Mrs. Erma Peak — ADDRESS: Shoshone, Idaho

18. CAUSE OF DEATH 4349
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral embolism c̄ Hemiparesis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 1959 *to* Oct 18, 1969, *that I last saw the deceased alive on* Oct 18, 1969 *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 476 J. E. Moar (Degree or title) MD.
23b. ADDRESS: Jerome Ida
23c. DATE SIGNED: 10/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 10-22-1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: Nov. 5, 1969
REGISTRAR'S SIGNATURE: Louella M. Schirer
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 23 1969
Bureau of Vital Statistics

State File No. 4759
Local Reg. No. 1259
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
c. LENGTH OF STAY (In this place) 13 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding 83330
d. STREET ADDRESS (If rural, give location) 430 3rd Ave. West.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Chester	Millard	Tate	Oct.	18,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 14, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Coal Miner 07	Coal Industry	Coalmont, Tenn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Tate	Tenn.	Bessie K. Brown	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-------	229-09-1453	X Norman H. Tate	Corral Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiomegalia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug 1, 1964, to Oct. 18, 1969, that I last saw the deceased alive on Oct. 18, 1969, and that death occurred at 9:50 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Maurice E Schee MD	Wendell, Idaho 83355	10-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-22-1969	Richfield Cemetery	Richfield, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 22, 1969	Louella M. Deburr	Eddie G. Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 27 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 28 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4760
Local Reg. No. 1260
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 232 5th. Ave. West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ERMA	CLEONE	ABBOTT	Oct. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Fe	White	Married	Aug. 18, 1910	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Spanish Fork, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harold Lloyd	Utah	Elizabeth Thomas	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	none	[signature]	Twin Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4368

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 11, 19 66 *to* Oct. 20, 19 69 *that I last saw the deceased alive on* Oct. 20, 1969, *and that death occurred at* 9:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Maurice E. Schuet MD	Wendell, Idaho 83355	10-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 23, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 27 1969	Lonella M. Deherer	W. L. Hove	E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4761
Local Reg. No. 1261
Reg. Dist. No. 440

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Interstate Hwy # 80 at Valley interchange 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Cailfornia 05
b. COUNTY Orange 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Long Beach
d. STREET ADDRESS (If rural, give location) 3279 Orange Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) Oliver
c. (Last) Carter, Jr.

4. DATE OF DEATH (Month) (Day) (Year) Oct. 23, 1969

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Mar 1, 1904
9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 21
10b. KIND OF BUSINESS OR INDUSTRY automobile
11. BIRTHPLACE (State or foreign country) Louisiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William O. Carter — BIRTHPLACE La.
14. MOTHER'S MAIDEN NAME Addie Martin — BIRTHPLACE No. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. not available
17. INFORMANT'S OWN SIGNATURE W. L. Hove — ADDRESS Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple fractures & wounds — INTERVAL BETWEEN ONSET AND DEATH none

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hiway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13270 (COUNTY) Jerome (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Drove off hiway - Thrown out.

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 4 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE R. M. Leber, M.D. 583 (Degree or title) Coroner 4
23b. ADDRESS Jerome
23c. DATE SIGNED 27 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE Oct. 29, 1969
24c. NAME OF CEMETERY OR CREMATORY Melrose Abbey
24d. LOCATION (City, town, or county) (State) Long Beach, California

DATE REC'D BY LOCAL REG. Oct. 27 1969
REGISTRAR'S SIGNATURE Louella M. Deherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4762
Local Reg. No. 1262
Reg. Dist. No. 440

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 28 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (rural)
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L. Martin Ranch 8 mi No. 3 mi E. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 409 1st. Ave. West

3. NAME OF DECEASED (Type or Print)
a. (First): Joe
b. (Middle): Onisimo
c. (Last): Gallegos

4. DATE OF DEATH (Month) (Day) (Year): Oct. 25, 1969

5. SEX: Male
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Aug. 2, 1926
9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Del Norte, Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Tomasino Gallegos — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Adelina Duran — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 524 18 7814
17. INFORMANT'S OWN SIGNATURE: X Beverly Norris — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushed chest. — INTERVAL BETWEEN ONSET AND DEATH: none

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hay field 33
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13270 Jerome Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Caught in hydraulic platform of hay stacker

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* approx 2:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. M. Fisher, M.D. Coroner.
23b. ADDRESS: Jerome Ida
23c. DATE SIGNED: 27 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Oct. 31, 1969
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
24d. LOCATION (City, town, or county) (State): Grand Junction, Colorado

DATE REC'D BY LOCAL REG.: Oct. 27, 1969
REGISTRAR'S SIGNATURE: Louella M. Saburer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4763
Local Reg. No. 1264
Reg. Dist. No. 440

BIRTH NO.

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 699

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): Jacobsen Apts.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	NICKOLINE	HALVERSON	Oct. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	June 5, 1879	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 64	Agriculture	Stanton Co., Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Halvord Halverson	Norway	Sarah Johnson	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 26 4992	X John Halverson	Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Thrombosis	12 hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Surgical shock.	16 hrs.
DUE TO (c)	Emergency surgery	24 hrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Myocardial insufficiency	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-26-69	Strangulated hernia L. Ing.	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-26, 1969, *to* 10-27, 1969, *that I last saw the deceased alive on* 10-27, 1969, *and that death occurred at* 7:52 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Reuben C. Matson M.D.	Jerome Idaho	10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 30, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 3, 1969	Lovella M. Deherer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4764
Local Reg. No. 1265
Reg. Dist. No. 440

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 216 4th. Ave. West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
OMA	CLAY	BOHANNAN	Oct. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 18, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Competition, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Clay Pridgeon	Missouri	Louiza Brown	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 28 7291	W. L. Howe	Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia; cardiac decompensation hypertension — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Fracture of left hip — 4 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

887X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10/25/69	Direct left hip - intertrochanteric. Pinning	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
10/24/69	Nursing home 3	Jerome, Jerome, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
10/24/69 m.		Fell on floor on way to bathroom

22. I hereby certify that I attended the deceased from 1959, 19__, to 10/28/69, 19__, that I last saw the deceased alive on 10/28/69, 19__, and that death occurred at 2:10P m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. Carlyle Smith	MD	Jerome, Idaho	10/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 31, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 3, 1969	Lauella M. Deherer	W. L. Howe	E-431

FIRM NAME: Howe Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4765
Local Reg. No. 1266
Reg. Dist. No. 440

BIRTH NO. RECEIVED

1. PLACE OF DEATH a. COUNTY Jerome 270 NOV 4 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome Bureau of Vital Statistics c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 099	d. STREET ADDRESS (If rural, give location) 500 East Ave. "H"

3. NAME OF DECEASED (Type or Print)	a. (First) Marion	b. (Middle) Marshall	c. (Last) Shane	4. DATE OF DEATH (Month) (Day) (Year) Oct. 28, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 19, 1915	9. AGE (In years last birthday) 54 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard man 06	10b. KIND OF BUSINESS OR INDUSTRY Livestock sale yards	11. BIRTHPLACE (State or foreign country) Marion, Indiana	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME no record	BIRTHPLACE no record	14. MOTHER'S MAIDEN NAME no record	BIRTHPLACE no record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. II 4 5	16. SOCIAL SECURITY NO. 518 05 8457	17. INFORMANT'S OWN SIGNATURE X Sarah Shane	ADDRESS Jerome, Idaho	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 25 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 Mar, 1969, *to* 28 Oct, 1969, *that I last saw the deceased alive on* 17 Oct, 1969, *and that death occurred at* 4:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE K. M. Fisher, M.D. 583 (Degree or title)	23b. ADDRESS Jerome Ida	23c. DATE SIGNED 30 Oct 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 1, 1969	24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery	24d. LOCATION (City, town, or county) (State) Jerome, Idaho
DATE REC'D BY LOCAL REG. Nov. 3 1969	REGISTRAR'S SIGNATURE Louella M. Scherer	25. EMBALMER W. L. Hove	LICENSE NO. E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

DEC 28 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

State File No. 4766
Local Reg. No. 2436
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 781
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hopsital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 48 b. COUNTY Clark 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Vancouver
d. STREET ADDRESS (If rural, give location) 1612 N.E. Edge Park Drive

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth b. (Middle) H. c. (Last) Cooper
4. DATE OF DEATH (Month) (Day) (Year) October 2, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 6, 1906
9. AGE (In years last birthday) 62
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Garden City, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Earl Hall BIRTHPLACE Unobtainable
14. MOTHER'S MAIDEN NAME Hannah Dustin BIRTHPLACE Unobtainable
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S OWN SIGNATURE Frank W. Cooper ADDRESS Vancouver, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cerebrovascular Disease — years
DUE TO (c) Diabetes Mellitus — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1969, to Oct 2, 1969, that I last saw the deceased alive on Oct 2, 1969, and that death occurred at 3:40 A m., from the causes and on the date stated above.

23a. SIGNATURE 454 C. Glennie (Degree or title) M.D.
23b. ADDRESS Hayden Lake, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE 10-7-1969
24c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens
24d. LOCATION (City, town, or county) (State) Vancouver, Wash.

DATE REC'D BY LOCAL REG. Oct. 7, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Billcliff
LICENSE NO. E-439
FIRM NAME English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38.206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969
JAN 16 1970
JUN 14 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4767
Local Reg. No. 2980
Reg. Dist. No. 120

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 250 — OCT 10 1969
b. CITY OR TOWN Athol-rural
c. LENGTH OF STAY (in this place) minn.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jct. U.S. 95 & State 54

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino-rural
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	C.	Space	Oct. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	married	Dec. 30, 1897	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
forman 17	logging	Weippe, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christian W. Space	Penn.	Ida Wildin	Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes WW I 3	518-18-8119	Ralph S. Space	Orofino

8199

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	accidental traumatism due to	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	automaile accident.	Sudden
DUE TO (c)	Skull fracture + crush injuries	Sudden
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	high way 06	Athol, Kootenia, 1328C Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Oct. 2, 69 1:30	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	auto accident

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood M.D. Coroner	Coeur d'alene Idaho	10-8-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal 3	Oct. 3, 69	Gilbert's Chapel	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 7, 1969	Lorraine K. Brush	Bill Luft	E-K 39

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 16 1969

APR 13 1970

JUL 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4768
Local Reg. No. 2958
Reg. Dist. No. 120

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai OCT 10 1969
b. CITY OR TOWN Athol-rural
c. LENGTH OF STAY (in this place) Infinite.
d. FULL NAME OF HOSPITAL OR INSTITUTION Jct. U.S. 95 & State 54

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater
c. CITY OR TOWN Orofino-rural
d. STREET ADDRESS Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Hazel	K.	Space	Oct. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	married	June 25, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
school teacher 12	public school	Soap Lake, Wash.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Kinnick	Mo.	Maud Marsh	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-30-7268	Hazel K Space	Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) accidental traumatism due

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) to automobile accident

DUE TO (c) multiple crush injuries

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
(a) Sudden
(b) "
(c)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident	highway 06	Athol	Kootenai 13-280	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Oct. 2, 69 1:30 a.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	auto accident

22. *I hereby certify that I attended the deceased from* Did Not, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. Coroner	Coeur d'Alene, Idaho	10-4-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal	Oct. 3, 69	Gilbert's Chapel	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 7, 1969	Lorraine K. Brush	Bill Cliff	E-439

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 1 6 1969

APR 1 3 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4769
Local Reg. No. 288
Reg. Dist. No. 120

BIRTH NO.

OCT 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' kAlene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Coeur d' Alene Homes 103	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Elsie	b. (Middle)	c. (Last) Rognli	4. DATE OF DEATH (Month) (Day) (Year) October 3, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 29, 1886	9. AGE (In years last birthday) 82 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Norway	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Available	BIRTHPLACE ----	14. MOTHER'S MAIDEN NAME Not Available	BIRTHPLACE ----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Art Olson	ADDRESS Idaho Coeur d'Alene	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

514X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 4-5 days.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility — Chronic.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1948, 19__, *to* Oct. 3, 1969, 19__, *that I last saw the deceased alive on* Sept 28, 1969, *and that death occurred at* 3:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE Lynn C. Fredrikson 177 (Degree or title) MD.	23b. ADDRESS Coeur d'Alene, Idaho	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-8-1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho
DATE REC'D BY LOCAL REG. Oct. 8, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Lipfinger Jr.	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4770
Local Reg. No. 297
Reg. Dist. No. 120

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 25
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
DURATION OF STAY (in this place) 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rathdrum
d. STREET ADDRESS (If rural, give location) Rathdrum, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) GLADYS
b. (Middle) L.
c. (Last) HESS

4. DATE OF DEATH (Month) (Day) (Year) Oct. 4, 1969

5. SEX Female

6. COLOR OR RACE Cau.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 1/4/20

9. AGE (In years last birthday) 49
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Rathdrum, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Samuel O'Donnell
BIRTHPLACE Washington

14. MOTHER'S MAIDEN NAME Esther Heyer
BIRTHPLACE Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Kenneth Hess
ADDRESS Rathdrum, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2060

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Monocytic Leukemia
DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-19, 1969, *to* 10-4, 1969, *that I last saw the deceased alive on* 10-4, 1969, *and that death occurred at* 3:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Hayden Lake, Idaho

23c. DATE SIGNED 10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/6/69

24c. NAME OF CEMETERY OR CREMATORY Pinegrove Cemetery

24d. LOCATION (City, town, or county) (State) Rathdrum, Idaho

DATE REC'D BY LOCAL REG. Oct. 17, 1969

REGISTRAR'S SIGNATURE Lorraine K Brush

25. EMBALMER Frank Houde

LICENSE NO. E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 10 1998

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4771
Local Reg. No. 2091
Reg. Dist. No. 120

BIRTH NO.

OCT 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 1 Mon.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Terrace Nur. Home 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Post Falls
d. STREET ADDRESS (If rural, give location) Rt. #2 Box 76

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	GRACE	B.	SHAEFER	Oct. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cau.	Widowed	1/3/1878	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Lawton, Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joe Booth	UNKNOWN	Charlot Ross	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	378-24-8681	Thelma Cook	Post Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 43 69 Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cerebrovascular Dis.
DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-11, 1969, *to* 10-4, 1969, *that I last saw the deceased alive on* 9-14, 1969, *and that death occurred at* 7:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G Glennie	M.D	Hayden Lake, Idaho	10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	10/5/69	Prindle Funeral Home	Lawton, Michigan

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 12, 1969	Lorraine K Brush	Frank Houde	E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4772
Local Reg. No. 285
Reg. Dist. No. 120

BIRTH NO. 69-4956

RECEIVED
OCT 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural 800

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moyie Springs
d. STREET ADDRESS (If rural, give location) Box 27

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Richard	J.	Burdick, Jr.	October 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	May 11, 1969		4	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 07
10b. KIND OF BUSINESS OR INDUSTRY -----
11. BIRTHPLACE (State or foreign country) Coeur d'Alene, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Richard J. Burdick, Sr. BIRTHPLACE Oregon
14. MOTHER'S MAIDEN NAME Cathleen Rorke BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Cathleen Boatman ADDRESS Idaho Moyie Springs

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9139

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Accidental Suffocation — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fell behind Cushion of Sofa

22. I hereby certify that I attended the deceased from Did not , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 583 4 Coroner	Coeur d'Alene, Idaho	10-8-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-9-1969	Evergreen Cemetery	Spirit Lake, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 9, 1969	Lorraine K. Brush	N. J. Riplinger, Jr.	E-397

FIRM NAME English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 14 1986.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 10 1969 Bureau of Vital Statistics

State File No. 4773
Local Reg. No. 292
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 280	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Washington 48 b. COUNTY Chelan 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harrison; LENGTH OF STAY (in this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wenatchee
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ozzie Resort 000	d. STREET ADDRESS (If rural, give location) 30-S-Gilmore Place

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) (None)	c. (Last) Ziuchkovski	4. DATE OF DEATH (Month) (Day) (Year) Oct. 5, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 17, 1919	9. AGE (In years last birthday) 50; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shift Foreman 26	10b. KIND OF BUSINESS OR INDUSTRY Aluminum Plant	11. BIRTHPLACE (State or foreign country) Nelson, B. C.,	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roman Ziuchkovski	BIRTHPLACE Canada	14. MOTHER'S MAIDEN NAME Anna Fill	BIRTHPLACE Canada	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II 4	16. SOCIAL SECURITY NO. 701-16-4279	17. INFORMANT'S OWN SIGNATURE Florence Ziuchkovski	ADDRESS Wenatchee Wn.	

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Myocardial Infarction	5 min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	2 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19—, *to* October 5, 19 69, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 7:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE G. E. Thompson 530	(Degree or title) MD	23b. ADDRESS 920 Ironwood Dr. Coeur d Alene Idaho	23c. DATE SIGNED 10-7-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE Oct. 6, 1969	24c. NAME OF CEMETERY OR CREMATORY Betts Funeral Home	24d. LOCATION (City, town, or county) (State) Wenatchee, Washington
DATE REC'D BY LOCAL REG. Oct. 8, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Tiplinger Jr.	LICENSE NO. E-397

FIRM NAME: Betts Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4774
Local Reg. No. 295
Reg. Dist. No. 120

Certificate of Death

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 281
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 3 Wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor Nur. 261 Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Post Falls, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): ALBERT
b. (Middle): JACOB
c. (Last): DORRIS

4. DATE OF DEATH (Month) (Day) (Year): Oct. 6, 1969

5. SEX: Male
6. COLOR OR RACE: Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 5/21/1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Post Master 08
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): Aiken, Minn.
12. CITIZEN OF WHAT COUNTRY?: U.SA

13. FATHER'S NAME: Jacob Dorris — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Louise Cazaa — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs. Roy Wright Kellogg — ADDRESS: Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/24

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Cardio Vascular

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Disease —
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov., 1962, *to* present, 19___, *that I last saw the deceased alive on* 10-6-69, 19___, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 128
23b. ADDRESS: 20 Ironwood Dr. Coeur d'Alene, Ida.
23c. DATE SIGNED: 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/8/69
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct. 15, 1969
REGISTRAR'S SIGNATURE: Lorraine K Brush
25. EMBALMER: Fred Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 14 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 15 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 10 1969
Bureau of Vital Statistics

State File No. 4775
Local Reg. No. 289
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 10'	d. STREET ADDRESS (If rural, give location) Rt. #2

3. NAME OF DECEASED (Type or Print)	a. (First) Conrad	b. (Middle) L.	c. (Last) Schaefer	4. DATE OF DEATH (Month) (Day) (Year) October 6, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 14, 1881	9. AGE (In years last birthday) 87 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 4	10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Lincoln, Nebr.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Schaefer	BIRTHPLACE Germany	14. MOTHER'S MAIDEN NAME (Unobtainable)	BIRTHPLACE Germany	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 519-20-0323	17. INFORMANT'S OWN SIGNATURE Cyril J. Schaefer	ADDRESS Coeur d'Alene, Id Box 319 Rt. #4	

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction	10 min
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	5 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* October 6, 19 69, *that I last saw the deceased alive on* October 6, 19 69, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE E. E. Thompson 530 (Degree or title) MD	23b. ADDRESS 920 Ironwood Dr. Coeur d'Alene Idaho	23c. DATE SIGNED 10-7-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-9-69	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG. Oct. 8, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. K. Riplinger Jr.	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

State File No. 4776
Local Reg. No. 296
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Terrace Nursing Home 340	d. STREET ADDRESS (If rural, give location) 813 Wallace Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) Lola	b. (Middle) E.	c. (Last) Guimond	4. DATE OF DEATH (Month) (Day) (Year) October 7, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 5, 1884	9. AGE (In years last birthday) 75 — IF UNDER 1 YR. Months 5 Days 2 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Minnesota	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Shiels	BIRTHPLACE ONtario	14. MOTHER'S MAIDEN NAME Mary Merrigan	BIRTHPLACE Bronswick Ida.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 519-10-4387	17. INFORMANT'S OWN SIGNATURE John W Guimond	ADDRESS Coeur d'Alene	

18. CAUSE OF DEATH 4123
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Jan. *, 19*62*, to* present *, 19____, that I last saw the deceased alive on* 10-7-69 *, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 128 (Degree or title)	23b. ADDRESS 920 Ironwood Dr. Coeur d'Alene,	23c. DATE SIGNED Ida. 10-8-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-10-1969	24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG. Oct. 15, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Ripling[illegible] Jr.	LICENSE NO. E-397

FIRM NAME English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 18 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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Certificate of Death

STATE OF IDAHO

State File No. 4777
Local Reg. No. 307
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
OCT 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeurd' Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
d. STREET ADDRESS (If rural, give location) Spirit Lake, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VIOLET	L.	FUNDIN	Oct. 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cau.	Married	4/9/03	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Ohio	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sidney Clark	Ohio	UNKNOWN	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	534-20-3147B	Wilbert Fundin	Spirit Lake, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) ASHD — INTERVAL BETWEEN ONSET AND DEATH 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 1968, *to* October, 1969, *that I last saw the deceased alive on* Oct 8, 1969 *and that death occurred at* 12:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. A. Thompson 530	MD	920 Ironwood Dr., Coeur d'Alene, Idaho	10/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/11/69	Greenwood Cemetery	Spirit Lake, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1969	Lorraine K. Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 1 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 6 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 9 1980

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 1778
Local Reg. No. 306
Reg. Dist. No. 120

BIRTH NO.

RECEIVED Bureau of Vital Statistics OCT 22 1969

1. PLACE OF DEATH
a. COUNTY Kootenai
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY (if not dead on arrival) 17 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) Post Falls, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LAUREL	V.	TROUT	Oct. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	9/7/1886	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Logger-Farmer 17	Logging	Indiana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Trout	U.S.A.	Emma Pyles	U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	539-09-6291	Roy Trout	Seattle, Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ASHD & C.F. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Laennec Cirrhosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-22-69, 19___, *to* 10-9-69, 19___, *that I last saw the deceased alive on* 10-9-69, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	920 Ironwood Dr. Coeur d'Alene, Ida.	10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/13/69	Evergreen Cemetery	Priest River Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1969	Lorraine K. Brush	Fred Noland	E-493

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 17 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4779
Local Reg. No. 294
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 107

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 1147 N. 14th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Gray	Dalgleish	October 10,1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Jan 6, 1890	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mill Superintendent 26	Hecla's Polaris	Park City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Dalgleish	Scotland	Catherine Gray	Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	518-03-3566A	Frances M Dalgleish	Coeur d'Alene, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

428X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Parenchymatous Nephritis — 2 weeks
581
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 60, *to* 10-10, 19 69, *that I last saw the deceased alive on* 10-9, 19 69, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 583 4 Coroner	Coeur d'Alene, Idaho	10-14-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-14-1969	Forest Cemetery	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 15, 1969	Lorraine K. Brush	Bill Huff	E-439

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 7 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4780
Local Reg. No. 307
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
OCT 22 1969
Bureau of Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 181

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Route #2 Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Route #2 Coeur d' Alene, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ERNEST		VERMILLION	Oct. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cau.	Never Married	2/5/1890	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNKNOWN 00	UNKNOWN	Ohio	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-01-4683A	Hospital Records	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4917

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cor Pulmonale — Month
DUE TO (c) Emphysema + Chronic Bronchitis — Years

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-28, 1969, *to* 10 Oct, 19 69, *that I last saw the deceased alive on* Oct 10, 1969, *and that death occurred at* 1:40 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. Glennie 904	M.D.	Hayden Lake, Idaho Hayden Lake Medical Clinic	10-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/13/69	Restlawn Memorial Pk.	Coeur D' Alene, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1969	Lorraine K. Brush	Fred Noland	E-493

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

DUTIES:

APR 28 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4781
Local Reg. No. 308
Reg. Dist. No. 120

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. VENTS OF STAY (in this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 211 Garden Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): CARL
b. (Middle): G.
c. (Last): WYCKMAN

4. DATE OF DEATH (Month) (Day) (Year): Oct. 10, 1969

5. SEX: Male
6. COLOR OR RACE: Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/8/1880
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Wheat Farming
11. BIRTHPLACE (State or foreign country): Burlington, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nels Wyckman — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Carolina Peterson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-42-5042
17. INFORMANT'S OWN SIGNATURE: Vendla Wyckman — ADDRESS: 211 Garden Ave. Coeur d' Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis & hypertension — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-14, 1967, *to* 10-10, 1969, *that I last saw the deceased alive on* 10-9, 1969, *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C G Barclay M.D.
23b. ADDRESS: Coeur d' Alene
23c. DATE SIGNED: 10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/14/69
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct 20, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred Noland
LICENSE NO.: E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 10 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4782
Local Reg. No. 302
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
OCT 22 1969
Bureau of Vital Stats.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 4th. St. Motor Hotel

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	VICTOR	LEE	HARMAN	Oct. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cau.	Widowed	4/22/1879	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mill Worker 17	P.F.I.	West Vir.	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Harman	West Vir.	Mary Diana Payne	West Vir.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-01-0435A	Ray Harman	Hayden Lake, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardio Pulmonary Arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March, 1960, *to* present, 19____, *that I last saw the deceased alive on* 10-11-69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	920 Ironwood Dri. Coeur d'Alene, Idaho	10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/14/69	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1969	Lorraine K. Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED OCT 22 1969 Bureau of Vital Statistics

State File No. 4783
Local Reg. No. 303
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene c. LENGTH OF STAY (In this place): D.O.A.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location): 1009 St. Maries St.

3. NAME OF DECEASED (Type or Print) a. (First): HENRY	b. (Middle):	c. (Last): KLUG	4. DATE OF DEATH (Month) (Day) (Year): Oct. 11, 1969		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	DATE OF BIRTH: 8/3/1888	9. AGE (In years last birthday): 81	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber 21	10b. KIND OF BUSINESS OR INDUSTRY: Plumbing	11. BIRTHPLACE (State or foreign country): Minnesota	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Henry Klug	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Hennrietta Kulwoski	BIRTHPLACE: Germany		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-03-0925	17. INFORMANT'S OWN SIGNATURE: Alice Klug	ADDRESS: 1009 St. Maries Cd'A, Ida		

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Probable Coronary occlusion

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): (DOA at Hospital. No History Known)

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. unknown

INTERVAL BETWEEN ONSET AND DEATH: Dead on arrival at hospital

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify): —	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Oct 11, 1969, *to* Oct 11, 1969, *that I last saw the deceased alive on* Never, 19__ *and that death occurred at* 3:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 313 [illegible] (Degree or title)	23b. ADDRESS: 411 Coeur d'Alene Ave, Coeur d'Alene Idaho	23c. DATE SIGNED: Oct. 16 '69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10/15/69	24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery	24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG.: Oct. 20 1969	REGISTRAR'S SIGNATURE: Lorraine K. Brush	25. EMBALMER: Fred Noland	LICENSE NO.: E-493

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 5 1969

NOV 0 8 2010

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED — STATE OF IDAHO — Bureau of Vital Statistics

State File No. 4784
Local Reg. No. 298
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY = Kootenai (28) — OCT 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. IF NOT IN CITY OR TOWN (If outside corporate limits, write RURAL and give township) STATE (If not in this State)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor Nursing Home (26)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai (28)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 2514 N. 7th

3. NAME OF DECEASED (Type or Print)
a. (First) Paul
b. (Middle)
c. (Last) Krause

4. DATE OF DEATH (Month) (Day) (Year) October 11, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH June 15, 1879

9. AGE (In years last birthday) 90
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (06)

10b. KIND OF BUSINESS OR INDUSTRY Common Labor

11. BIRTHPLACE (State or foreign country) Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Not Available
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Not Available
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-01-3022A

17. INFORMANT'S OWN SIGNATURE Lon Morris — ADDRESS Coeur d'Alene, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7130

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic and acute Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic hypertrophic arthritis — 20 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1964, *to* Oct 11, 1969, *that I last saw the deceased alive on* Oct. 7, 1969, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Hamilton A. Brunner MD (183)

23b. ADDRESS Coeur d'alene Ida

23c. DATE SIGNED 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-17-1969

24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Oct. 15, 1969

REGISTRAR'S SIGNATURE Lorraine K Brush

25. EMBALMER Bill Huff

LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Gumprecht

Certificate of Death

STATE OF IDAHO

State File No. 4785
Local Reg. No. 305
Reg. Dist. No. 120

RECEIVED OCT 22 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 2514 N. 7th-Pinewood Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Forrest	E.	Powell	October 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Feb. 7, 1881	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 22
10b. KIND OF BUSINESS OR INDUSTRY: Shoe Store
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Edwin Powell
BIRTHPLACE: (unobtainable)
14. MOTHER'S MAIDEN NAME: Virginia Thurston
BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 493-03-4028
17. INFORMANT'S OWN SIGNATURE: Clyde M. Powell
ADDRESS: Box Post Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4789

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1968 *to* Oct [illegible], 19[illegible], *that I last saw the deceased alive on* Oct 13, 1969, *and that death occurred at* 9P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm Gumprecht MD 142	302 N 5th St	14 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-17-1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct. 17, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Gauff
LICENSE NO.: E-439
FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4786
Local Reg. No. 300
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
OCT 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 2514 N. 7th-Pinewood Manor N.H.

3. NAME OF DECEASED (Type or Print)
a. (First): C.
b. (Middle): Jane
c. (Last): Depew

4. DATE OF DEATH (Month) (Day) (Year): October 14, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 17, 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Granite Lake, Wisc.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: --- Wilkin — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Harriett Ward — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 519-60-9854
17. INFORMANT'S OWN SIGNATURE: Ivy V. Upchurch — ADDRESS: Coeur d'Alene Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Thrombosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1957, *to* _____, 1969, *that I last saw the deceased alive on* Sept 20, 1967 *and that death occurred at* 12 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 142
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED: 16 Oct

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-18-1969
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Oct 17, 1969
REGISTRAR'S SIGNATURE: Lorraine K Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel, Coeur d'Alene

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 2 7 1989

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4787
Local Reg. No. 304
Reg. Dist. No. 120

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 22 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cataldo
c. LENGTH OF [illegible] (If outside place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. #1 Box 236 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cataldo
d. STREET ADDRESS (If rural, give location): Rt. #1 Box 236

3. NAME OF DECEASED (Type or Print)
a. (First): Grace
b. (Middle): V.
c. (Last): Papineau

4. DATE OF DEATH (Month) (Day) (Year): October 17, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 21, 1895
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Wardner, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James J. Bell — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Mary — BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 518-01-760 D
17. INFORMANT'S OWN SIGNATURE: Don English — ADDRESS: Coeur d'alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood, M.D. 583 4 Coroner
23b. ADDRESS: Coeur d'alene Idaho
23c. DATE SIGNED: 10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
24b. DATE: 10-21-69
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cem.
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: Oct. 21, 1969
REGISTRAR'S SIGNATURE: Lorraine K Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4788
Local Reg. No. 313
Reg. Dist. No. 120

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (If not in place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 181

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Augusta
b. (Middle)
c. (Last) Larson

4. DATE OF DEATH (Month) (Day) (Year) October 21, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH March 2, 1884
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months 7 Days 21 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME (Unobtainable) BIRTHPLACE (Unobtainable
14. MOTHER'S MAIDEN NAME (Unobtainable) BIRTHPLACE (Unobtainable)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-22-1248D
17. INFORMANT'S OWN SIGNATURE Mrs. Frances Keeth ADDRESS Spokane, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD
DUE TO (c) Diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Recent hip fracture

19a. DATE OF OPERATION 8-17-69
19b. MAJOR FINDINGS OF OPERATION Fracture Femur
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* Oct 21, 1969, *that I last saw the deceased alive on* Oct 20, 1969, *and that death occurred at* 1:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Philip S. Glennie M.D. 904 (Degree or title)
23b. ADDRESS Hayden Lake Idaho
23c. DATE SIGNED 10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Buril Removal 3
24b. DATE 10-25-1969
24c. NAME OF CEMETERY OR CREMATORY Fairmont Cemetery
24d. LOCATION (City, town, or county) Spokane (State) Wash.

DATE REC'D BY LOCAL REG. Oct 30, 1969
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 31 1969 Bureau of Vital

Certificate of Death

STATE OF IDAHO

State File No. 4789
Local Reg. No. 311
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alem
c. LENGTH OF STAY (in this place) 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 714 Third St.

3. NAME OF DECEASED (Type or Print)
a. (First) BULA
b. (Middle)
c. (Last) MUELLER

4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	9/8/1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Kansas	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dan Timberlake	Kentucky	Eva Harshman	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-38-8782	Fred Mueller	714 Third St. Cd'A,Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suppurative pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: 1-2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Intermittent biliary obstruction — years
DUE TO (c) Cholelithiasis & cholecystitis — years

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Shanley M.D. 026	Coeur d'Alene	10-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/24/69	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 27, 1969	Lorraine K. Brueck	Frank Houde	E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 3 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 30 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4790
Local Reg. No. 308
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
OCT 31 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 280 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spirit Lake
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spirit Lake
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ralph	Ernest	Dotson	October 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Jan. 9, 1927	42		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 08	Street Dept.	Mace, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Floyd E. Dotson	Arkansas	Myrtle Polley	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	519-22-1781	x Mrs O B Dotson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

398X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rheumatic Heart Disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did not *, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. Coroner	Coeur d'Alene Idaho	10-27-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 28, 1969	Pinegrove Cemetery	Rathdrum, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 28, 1969	Lorraine K Brush	Bill Duff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 5 1969
APR 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
OCT 31 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4791
Local Reg. No. 310
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorail Hospital 10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 1924 Lakeside Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Peter b. (Middle) C. c. (Last) Knutson

4. DATE OF DEATH (Month) (Day) (Year): October, 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Sept. 18, 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sherman, Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ivor Knutson — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-01-0590
17. INFORMANT'S OWN SIGNATURE: X Violet T. Knutson ADDRESS: Coeur d'Alene, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19 50, *to* 10-23, 19 69, *that I last saw the deceased alive on* 10-23, 19 69, *and that death occurred at* 8:[illegible] P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 583 4 (Degree or title)	Coeur d'alene Idaho	10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 27, 1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 28, 1969	Lorraine K. Brush	[signature]	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 3 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 1 0 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4792
Local Reg. No. 316
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spirit Lake
d. STREET ADDRESS (If rural, give location): Spirit Lake, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): ALMER
b. (Middle): ARRON
c. (Last): SNYDER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 25, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 12, 1906

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Montana

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Snyder
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Ruby Stevenson
BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 516-10-7801

17. INFORMANT'S OWN SIGNATURE: Dorothy Snyder
ADDRESS: Spirit Lk. Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Left pneumathorax — INTERVAL BETWEEN ONSET AND DEATH: Two weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Trauma — Two weeks
DUE TO (c): Auto Accident

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Emphysema — 5 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE / (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Road 06

21c. (CITY, TOWN, OR TOWNSHIP) 13280: 1 mi. N. Highway 4
(COUNTY): Kootenai
(STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 13, 1969 9p m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: One auto accident

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD 530

23b. ADDRESS: 920 Ironwood Dr Coeur d'Alene Idaho

23c. DATE SIGNED: 10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 1027/69

24c. NAME OF CEMETERY OR CREMATORY: Franzen Funeral Home

24d. LOCATION (City, town, or county) (State): Livingston, Montana

DATE REC'D BY LOCAL REG.: Oct 31, 1969

REGISTRAR'S SIGNATURE: Lorraine K Brush

25. EMBALMER: Frank Houde
LICENSE NO.: E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 1 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 1 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 1 4 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1969 Bureau of Vital Statistics

State File No. 4793
Local Reg. No. 314
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 13 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 517 N. 17th. St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 517 N. 17th. St.

3. NAME OF DECEASED (Type or Print)
a. (First) HELEN
b. (Middle) M.
c. (Last) SCHALLOCK

4. DATE OF DEATH (Month) (Day) (Year) Oct. 26, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug. 4, 1901
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Lechler — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Marie Boerger — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 501-09-1110B
17. INFORMANT'S OWN SIGNATURE Gerhardt Schallock — ADDRESS 517N17th St. Coeur d' Alene, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19 53, to _____, 19 69, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Dr M Gimpreshit MD 192
23b. ADDRESS 302 N 5 St
23c. DATE SIGNED 28 Oct

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/28/69
24c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Oct. 31, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Frank Houde
LICENSE NO. E-521

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

MAY 4 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the [illegible] obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance or [illegible].

3. THE REGISTRAR can issue a burial or removal permit ONL[illegible] completed death certificate, including the SIGNATURES IN BLACK for under items [illegible].

PENALTIES: Under the Idaho law, it is a [illegible] to

(a) Knowingly supply false information [illegible] death certificate;
(b) Neglect or refuse to certify to the cause of death [illegible] in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person [illegible] ng FIRST obtained from the local registrar in the district WHERE [illegible]
(d) Alter a certificate on file in the office of [illegible]

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfa[illegible]rtion of this item. The city or town and street address or route number [illegible] OCCURRED. For deaths occurring in hospitals, maternity homes, or [illegible] and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have [illegible] the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person [illegible] where death occurred for less than one year, give address of FORMER RESIDENCE. The usual place of the deceased may be in a county or state other than the county of actual [illegible]

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 20

The personal and statistical particular[illegible] authenticated by the signature of the informant, who may be any competent per[illegible]

The statement of facts relating to the [illegible] shall be signed by the undertaker or person acting as such.

The medical certificate shall be made [illegible] last in attendance on the deceased, who shall specify the time in attendance [illegible] saw the deceased alive and the hour of the day at which death occurred. And he [illegible] death, so as to show the course of disease or sequence of causes [illegible] primary cause, and also the contributory causes, if any, and the durat[illegible] factory terms, indicating only symptoms of disease or conditions [illegible] sufficient for issuing a burial or removal permit; and any certifi[illegible] ired by the state registrar as indefinite and unsatisfactory, [illegible] for correction and definition. The international classifica[illegible] used by all physicians in stating the cause of death in the medica[illegible] ich may be the result of either disease or violence, shall be caref[illegible] its nature shall be stated, and whether (probably) accidental, [illegible]

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4794
Local Reg. No. 315
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 6 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 281
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 2514 N. 7th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lura	nmn	Shaffer	October 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Mar. 25, 1873	96		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Ohio	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Wm Coffin	New Hampshire	Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	519-60-8060	v Mrs. John Hill	Rathdrum Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 7963 Natural Causes - Exact
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cause Undetermined
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1963, 19____, to Oct. 1969, 19____, that I last saw the deceased alive on 9/29/69, 19____, and that death occurred at 8:15A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lynn O. Sederburg MD	Coeur d'Alene Idaho	10/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 30, 1969	Pinegrove Cemetery	Rathdrum, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 31, 1969	Lorraine K. Brush	Bill Duff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4795
Local Reg. No. 321
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Coeur d' Alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene,
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Vandela; b. (Middle); c. (Last) Severin

4. DATE OF DEATH (Month) (Day) (Year): October 28, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 10, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing-Housewife 13

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rhinelander, Wisc.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ed. Strom
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Mary Larson
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 519-22-9188

17. INFORMANT'S OWN SIGNATURE: X Geraldine L. Heitz
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4122

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral vascular accident

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Hypertensive cardiovasc disease

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 1/2 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept, 1965, *to* Oct 28, 1969, *that I last saw the deceased alive on* April 28, 1969, *and that death occurred at* 9:10a *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. Wray Wilson MD 568 (Degree or title)

23b. ADDRESS: Coeur d'Alene, Idaho

23c. DATE SIGNED: 10/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-31-1969

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.: Nov 6, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: W. F. Bissinger, Jr.

LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4796
Local Reg. No. 312
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY Kootenai 24	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place) day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location) Rt. #1 Box 270

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ervin	Henry	Bruss	October 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 29, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber 21	Plumbing Shop	Winona, Minn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Bruss	Minn.	(Not Available)	(Not Availabl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	471-10-6481	Clara R Bruss	Post Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

201X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hodgkins disease, — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gastrointestinal bleeding
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/9/69, 19__, *to* 10/29/69, 19 69, *that I last saw the deceased alive on* 10/29/69, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvin J Powell 912	M.D.	920 Ironwood Dr.	10/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct. 30, 1969	Woodlawn Cemetery	Winona, Minn.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 31, 1969	Lorraine K Bruch	Bill Duff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH—63021

DUTIES:

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(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

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STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of Kootenai

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)

for Erwin Henry Bruss (Name on Original Certificate) who died (Was Born or Died) on Oct 29, 1969 (Date of Event)

in Coeur d'Alene, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#3 Name	Erwin	Ervin

Subscribed and sworn to before me this 14th day of November 1969

Helen R. Robertson

Notary Public, residing at Coeur d'Alene

My commission expires 3-18-73

(Seal)

Signed Don C. English

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1133 4th St. Cda Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Kootenai

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 14th day of November 1969

Helen R. Robertson

Notary Public, residing at Coeur d'Alene

My commission expires 3-18-73

(Seal)

Signed M. F. Riplinger Jr.

(Signature of Any Credible Person)

(Street Address, City, State)

FORM DH 60-155

11-13-69

NOV 1 8 1969

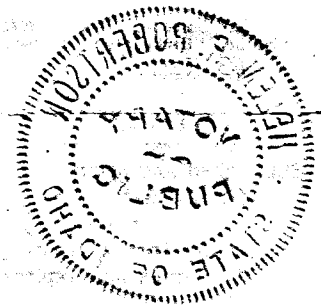

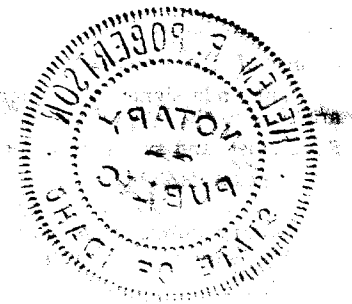

Certificate of Death

STATE OF IDAHO

State File No. 4797
Local Reg. No. 317
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Northwest Blvd. & Highway #10 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Washington 11 b. COUNTY: Benton 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Prosser
d. STREET ADDRESS (If rural, give location): Rt. #2 Box 137

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	Joseph	Chott	October 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		Feb. 7, 1949	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	E.W.S.C.	Yakima, Wash.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph J. Chott	Yakima, Washington	Jean C. Bradley	David City, Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (BE)	ADDRESS
no	none	538-52-0501	Mrs Jean Chott	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	accidental traumatism due to	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	automobile accident.	Sudden
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

8169

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13280 (COUNTY) (STATE)
accident	Highway 06	Coeur d'alene Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
10-29-'69. m.		Car ran off road and struck a tree

22. *I hereby certify that I attended the deceased from* Did not , 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood '68 M.D. Coroner	Coeur d'alene Idaho	10-31-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct. 30, 1969	Smith Funeral Home	Grandview, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1969	Lorraine K. Brush	Bill Huff	E-439

FIRM NAME: Smith Funeral Home
Grandview, Wash.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

DUTIES:

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PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4798
Local Reg. No. 318
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Northwest Blvd. & Highway 10 #10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Washington
b. COUNTY: Benton 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Benton City
d. STREET ADDRESS (If rural, give location): Box 123

3. NAME OF DECEASED (Type or Print): a. (First) John; b. (Middle) Franklin; c. (Last) Howard

4. DATE OF DEATH (Month) (Day) (Year): October 29, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: Oct. 21, 1949

9. AGE (In years last birthday): 20
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: E.W.S.C.

11. BIRTHPLACE (State or foreign country): Lahina, Hawaii

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lester Joesph Howard
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Eluree Alderman
BIRTHPLACE: Orofino, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 538-46-6593

17. INFORMANT'S OWN SIGNATURE (BZ): Mrs Shelley Howard
ADDRESS: Box 12 Benton Cit

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): accidental traumatism due
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): to automobile accident
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: sudden

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Highway 95
21c. (CITY, TOWN, OR TOWNSHIP) 250 **(COUNTY)** **(STATE)**: Coeur d'alene Kootenai Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-29-'69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Car ran off road & struck a tree

22. *I hereby certify that I attended the deceased from* Did not , 19 , to , 19 , *that I last saw the deceased alive on* , 19 , *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Ward M.D. Coroner 583
23b. ADDRESS: Coeur d'alene Idaho
23c. DATE SIGNED: 10-31-'69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct. 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Benton Memorial Chapel
24d. LOCATION (City, town, or county) (State): Prosser, Washington

DATE REC'D BY LOCAL REG.: Nov. 6, 1969
REGISTRAR'S SIGNATURE: Lorraine K Brush
25. EMBALMER: Bill Huff
LICENSE NO.: E-439
FIRM NAME: Benton Memorial Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 7 1969

MAR 1 9 2014

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended November 18, 1969

Certificate of Death
STATE OF IDAHO

State File No. 4799
Local Reg. No. 322
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Northwest Blvd. & Highway #10 580

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 48 b. COUNTY Benton 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Benton City
d. STREET ADDRESS (If rural, give location) P. O. Box 86

3. NAME OF DECEASED (Type or Print) a. (First) Michael b. (Middle) Charles c. (Last) Wright
4. DATE OF DEATH (Month) October (Day) 29, (Year) 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Oct. 28, 1949
9. AGE (In years last birthday) 20 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY E.W.S.C.
11. BIRTHPLACE (State or foreign country) Pinckneyville, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Less F. Wright BIRTHPLACE Pinckneyville, Ill.
14. MOTHER'S MAIDEN NAME Clara M. Ellinger BIRTHPLACE St. Louis, Missouri
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 534-46-1968
17. INFORMANT'S OWN SIGNATURE Less F. Wright ADDRESS Box 86, Benton City

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Internal injuries — INTERVAL BETWEEN ONSET AND DEATH 2 hr.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident 2
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) Coeur d'Alene (COUNTY) Kootenai (STATE) Idaho 13280
21d. TIME OF INJURY (Month) Oct 29, (Day) (Year) 1969 (Hour) 2 a m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]
21f. HOW DID INJURY OCCUR? Car hit tree

22. *I hereby certify that I attended the deceased from* 10/29/69, 19____, *to* 10/29/69, 19____, *that I last saw the deceased alive on* 10/29/69, 19____, *and that death occurred at* 4:27 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE H. Don Moseley, M.D. 375 (Degree or title)
23b. ADDRESS 421 Coeur d'Alene Ave.
23c. DATE SIGNED 10-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Oct 30, 1969
24c. NAME OF CEMETERY OR CREMATORY Benton Memorial Chapel
24d. LOCATION (City, town, or county) Prosser, Washington (State)

DATE REC'D BY LOCAL REG. Nov 6, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Benton Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Michael Charles Wright (Name on Original Certificate) who died (Was Born or Died) on October 29, 1969 (Date of Event)
in Coeur d'Alene, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date) are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#14 Mother's Maiden Name	Sue Ellenger	Clara M. Ellinger

Subscribed and sworn to before me this 14 day of November, 19 69

..... Notary Public, residing at Kirkland

My commission expires 1-13-73

(Seal)

Signed Lillian Phelps
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

P.O. Box 61 Benton City, Wash.
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Washington } ss.
County of Benton }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 14 day of November, 19 69

..... Notary Public, residing at Kirkland

My commission expires 1-13-73

(Seal)

Signed Beverly King
(Signature of Any Credible Person)

Rt 1 Box 296 - Benton City - Wash
(Street Address, City, State)

FORM DH 60-155

L. 11-12-69 R

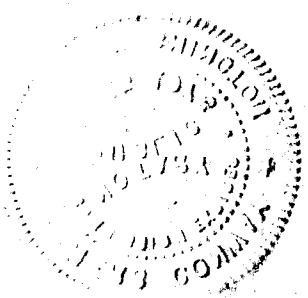

Certificate of Death

STATE OF IDAHO

State File No. _____
Local Reg. No. 322
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Northwest Blvd. & Highway #10

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
a. STATE: Washington
b. COUNTY: Benton
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Benton City
d. STREET ADDRESS (If rural, give location): P.O. Box 86

3. NAME OF DECEASED (Type or Print): a. (First) Michael b. (Middle) Charles c. (Last) Wright

4. DATE OF DEATH: (Month) October (Day) 29, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: Oct. 28, 1949

9. AGE (In years last birthday): 20
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: E.W.S.C.

11. BIRTHPLACE (State or foreign country): Pinckneyville, Ill.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Less F. Wright
BIRTHPLACE: Pinckneyville, Ill.

14. MOTHER'S MAIDEN NAME: Sue Ellenger
BIRTHPLACE: St. Louis, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 534-46-1968

17. INFORMANT'S OWN SIGNATURE (Type): Less F Wright
ADDRESS: Box 86 Benton City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Internal injuries
INTERVAL BETWEEN ONSET AND DEATH: 2 hr.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) Coeur D'Alene (COUNTY) Kootenai (STATE) Idaho

21d. TIME OF INJURY: (Month) Oct. (Day) 29, (Year) 1969 (Hour) 2a m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR? Car hit Tree

22. *I hereby certify that I attended the deceased from* 10/29/69, 19____, *to* 10/29/69, 19____, *that I last saw the deceased alive on* 10/29/69, 19____, *and that death occurred at* 4:27 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. Don Moseley, M.D. H. Don Moseley M.D.
23b. ADDRESS: 421 Coeur d'Alene Ave.
23c. DATE SIGNED: 10/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Oct. 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Benton Memorial Chapel
24d. LOCATION (City, town, or county) (State): Prosser, Washington

DATE REC'D BY LOCAL REG.: Nov 6, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: W. K. Tiplinger Jr.
LICENSE NO.: E-397

FIRM NAME: Benton Memorial Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 18 1969
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. NOV 26 1969
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4800
Local Reg. No. 325
Reg. Dist. No. 120

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

NOV 12 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (If in hospital or place) D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Worley Rural Route #1
d. STREET ADDRESS (If rural, give location) Route #1 Worley

3. NAME OF DECEASED (Type or Print)
a. (First) KENNETH
b. (Middle) JAMES
c. (Last) CHRISTENSEN

4. DATE OF DEATH (Month) (Day) (Year) Oct. 30, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 8/1/20
9. AGE (In years last birthday) 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Christensen — BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Anna Johansen — BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 531-16 5012
17. INFORMANT'S OWN SIGNATURE Jean Christensen — ADDRESS Route #1 Worley, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

873X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) accidental asphyxia by — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carbon Monoxide.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Garage at home 01
21c. (CITY, TOWN, OR TOWNSHIP) 13280 (COUNTY) (STATE) Worley Rural Rte 1. Kootenai Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-30-'69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Truck engine running in Garage.

22. *I hereby certify that I attended the deceased from* Did not, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 583 4 (Degree or title) Coroner
23b. ADDRESS Coeur d'alene, Idaho
23c. DATE SIGNED 11-3-'69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE 10/3/69
24c. NAME OF CEMETERY OR CREMATORY Pines Cemetery
24d. LOCATION (City, town, or county) (State) Opportunity, Washington

DATE REC'D BY LOCAL REG. Nov. 7, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Frank Houde — LICENSE NO. E-521

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4801
Local Reg. No. 109
Reg. Dist. No. 200

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

OCT 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (In this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 719 South Main

3. NAME OF DECEASED (Type or Print)
a. (First): Adilene
b. (Middle): Caroline
c. (Last): Broenneke

4. DATE OF DEATH (Month) (Day) (Year): October 3 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 1, 1911
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Leland, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Russell Rodgers — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Martha Bleck — BIRTHPLACE: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-18-3161
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Leviston, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Left Coronary occlusion

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Ventricular fibrillation
DUE TO (c): Cardiac Arrest

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Fibroids & antenna Polyp.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Pulmonary Embolic
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-13, 1939, *to* Oct 3, 1969, *that I last saw the deceased alive on* Oct 1, 1969, *and that death occurred at* 11:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Joseph G. Wilson MD 567 (Degree or title)
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-8-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county): Moscow (State): Idaho

DATE REC'D BY LOCAL REG.: 9 Oct 1969
REGISTRAR'S SIGNATURE: Maynel R. Heickari
25. EMBALMER: E. Pete Albertson — LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 24 1969

FEB 4 1970

MAR 26 1970

APR 26 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 13 1969 Bureau of Vital Statistics

State File No. 4802
Local Reg. No. 110
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
LENGTH OF STAY (in this place): 7 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 miles South of Princeton 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
d. STREET ADDRESS (If rural, give location): 2 miles South of Princeton

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARIE	LANE	REYNOLDS	October 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married	October 11, 1961	7				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 00	None	Moscow, Idaho	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Norman Reynolds	Potlatch, Idaho	Dolores Derry	Sanders, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Norman R. Reynolds	Rt. 1 Princeton, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 7516 Biliary Atresia — INTERVAL BETWEEN ONSET AND DEATH: ~ 8 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) w/ Portal Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/10, 1963 *to* 10/3, 1969, *that I last saw the deceased alive on* 10/3, 1969, *and that death occurred at* 6 15/p m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Norris A. Biggerstaff, M.D. 042 (Degree or title)	225 Sixth St. Potlatch, Idaho	10/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 7, 1969	Mendenhall Cemetery	Latah County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9 Oct 1969	Wayne R Heiskell	E. A. Ellithorpe	1260

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Kimball Funeral Home, Palouse, Wa.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. [ICA 38-206 and 215.] Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4803
Local Reg. No. 108
Reg. Dist. No. 200

BIRTH NO.

RECEIVED OCT 13 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah County Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. -1 Box-158

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joyce	Doris	Iverson	October	4	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	April 5, 1918	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Moscow, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles L. Davidson	Wheaton, Minn.	Lettie Keeney	Troy, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-14-6312	Johnnie Iverson	Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Astrocytoma 1727

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

INTERVAL BETWEEN ONSET AND DEATH: 1 hrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-18 69	Astrocytoma Surgery at Deaconess Hosp Spokane	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-8, 1967, *to* 10-4, 1969, *that I last saw the deceased alive on* 10-4, 1969, *and that death occurred at* 9:56 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
LaRele J. Stephens M.D.	Moscow 127 W. 3rd St	10-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	10-7-1969	Moscow, Cemetery	Moscow	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10 Oct 1969	Wayne R Verkaire	E. Pete Albertson	E-525

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4804
Local Reg. No. 117
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 27 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 15 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Troy
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Arthur
b. (Middle): William
c. (Last): Fredrickson

4. DATE OF DEATH (Month) (Day) (Year): Oct 8 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb 11, 1907
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Troy, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carl Fredrickson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-5358
17. INFORMANT'S OWN SIGNATURE: Clifford Earl Fredrickson — ADDRESS: Lewiston, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): acute cardio-respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Chronic Emphysema + Arteriosclerosis.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Intestinal Flu

49 2X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1959, to 10-8, 1969, that I last saw the deceased alive on 10-8-69, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: O M H Drury 148 (Degree or title): M.D.
23b. ADDRESS: Troy Idaho
23c. DATE SIGNED: 10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 11, 1969
24c. NAME OF CEMETERY OR CREMATORY: Burnt Ridge Cemetery
24d. LOCATION (City, town, or county) (State): near Troy Idaho

DATE REC'D BY LOCAL REG.: 17 Oct 1969
REGISTRAR'S SIGNATURE: Wayne K Heiskari
25. EMBALMER: Donald Ward — LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4805
Local Reg. No. 114
Reg. Dist. No. 200

Certificate of Death

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 14 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Knute
b. (Middle): K.
c. (Last): Berge

4. DATE OF DEATH (Month) (Day) (Year): Oct 9 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Nov 8, 1890
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): warehouse foreman 26
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 503-24-3263
17. INFORMANT'S OWN SIGNATURE: X [signature] — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1541

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Lobar pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Intestinal obstruction
DUE TO (c): Metastatic carcinoma of rectum

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Uremia

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION: 9-29-69
19b. MAJOR FINDINGS OF OPERATION: Kidneys obstructed. Ileoloop bladder
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sep 29, 1969, *to* Oct 9, 1969, *that I last saw the deceased alive on* 9-29, 1969, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 567 (Degree or title): MD
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county): Moscow — (State): Idaho

DATE REC'D BY LOCAL REG.: 15 Oct 1969
REGISTRAR'S SIGNATURE: Wayne R Huskair
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 23 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4806
Local Reg. No. 113
Reg. Dist. No. 200

Certificate of Death

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Genesee Welding Shop 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
d. STREET ADDRESS (If rural, give location): 4 mi. South

3. NAME OF DECEASED (Type or Print)
a. (First): Jerome
b. (Middle): M.
c. (Last): Kasper

4. DATE OF DEATH (Month) (Day) (Year): Oct 10 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug 12, 1937
9. AGE (In years last birthday): 32 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Matthew Kasper — BIRTHPLACE: Uniontown, Wn.
14. MOTHER'S MAIDEN NAME: Mary Krick — BIRTHPLACE: Uniontown, Wn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-40-8157
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

928X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive head and chest injuries — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): welding shop 03
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Genesee 13290 Latah Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 10 1969 4p
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: tractor rolled over

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] G.W. Sheaver Jr. 932 J.P.
23b. ADDRESS: Genesee, Idaho
23c. DATE SIGNED: 10-11-1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: St. Marys Catholic Cem.
24d. LOCATION (City, town, or county) (State): Gensee Idaho

DATE REC'D BY LOCAL REG.: 13 Oct 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: Andrew F. Vassar — LICENSE NO.: E-315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 20 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 4 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 27 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4807
Local Reg. No. 118
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 4 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 132 No. Hayes St.

3. NAME OF DECEASED (Type or Print): a. (First) Russell; b. (Middle) Crossley; c. (Last) Stage

4. DATE OF DEATH: (Month) Oct (Day) 11 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Feb 14, 1904

9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Monotype Operator 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Binghamton, N.Y.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Stage — BIRTHPLACE: Penn.

14. MOTHER'S MAIDEN NAME: Belle Crossley — BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 026-10-6555 A

17. INFORMANT'S OWN SIGNATURE: x Helen M. Stage — ADDRESS: 132 N. Hayes St

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Accidental Blow to head — 7 hrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Myelogenous Leukemia — 6 mos.
Blindness & Deafness — Yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Moscow 13291 Latah Idaho

21d. TIME OF INJURY (Month) Oct. (Day) 10 (Year) 1969 (Hour) 11:30 AM

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Fell in bedroom striking head on chair

22. *I hereby certify that I attended the deceased from* ____, 1969, *to* Oct. 11, 1969, *that I last saw the deceased alive on* Oct. 11, 1969, *and that death occurred at* 6:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Brooks 058 MD

23b. ADDRESS: Moscow Idaho

23c. DATE SIGNED: 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct 14, 1969

24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery

24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 17 Oct 1969

REGISTRAR'S SIGNATURE: Harper Heiskari

25. EMBALMER: E. Pete Albertson

LICENSE NO.: E-525

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4808
Local Reg. No. 115
Reg. Dist. No. 200

Certificate of Death

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (In this place) 50 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
d. STREET ADDRESS (If rural, give location) 1½ miles West of Viola

3. NAME OF DECEASED (Type or Print)
a. (First) CORA
b. (Middle)
c. (Last) PARKER

4. DATE OF DEATH (Month) (Day) (Year) October 12, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH February 4, 1882
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Whitman County, Washington
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME George Hill — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Melissa Hammer — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 038-30-0289
17. INFORMANT'S OWN SIGNATURE Melba Ruth Parker — ADDRESS Pullman, Wa. 99163

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis
DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Fractured left hip
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-15, 1939, *to* Oct 12, 1969, *that I last saw the deceased alive on* 9-28, 1969 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Joseph E. Wilson M.D. 567 (Degree or title)
23b. ADDRESS Moscow Idaho
23c. DATE SIGNED 10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE 10-15-69
24c. NAME OF CEMETERY OR CREMATORY Coleman Cemetery
24d. LOCATION (City, town, or county) (State) Whitman County, Washington

DATE REC'D BY LOCAL REG. 16 Oct 1969
REGISTRAR'S SIGNATURE Mayne R Heiskari
25. EMBALMER E. A. Ettlethorpe
LICENSE NO. 1260

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Kimball Funeral Home, Palouse, Wa.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 26 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 28 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4809
Local Reg. No. 116
Reg. Dist. No. 200

BIRTH NO.

RECEIVED
OCT 27 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 27 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 719 S. Main

3. NAME OF DECEASED (Type or Print)
a. (First) Martha
b. (Middle) Louise
c. (Last) Rodgers

4. DATE OF DEATH (Month) (Day) (Year) Oct. 14, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Feb 7, 1889

9. AGE (In years last birthday) 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Arlington, Minn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Michael Bleck
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Anelia Kurtzweg
BIRTHPLACE Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-54-0387

17. INFORMANT'S OWN SIGNATURE X Raymond Rodgers
ADDRESS Orofino, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4310 Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis
DUE TO (c) with hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic Myocarditis with failure

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-20, 1942 *to* Oct 14, 69, *that I last saw the deceased alive on* 10-12, 1969, *and that death occurred at* 7:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE Joseph O'Sullivan (Degree or title) MD
23b. ADDRESS Moscow Idaho
23c. DATE SIGNED 10-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 17, 1969
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 20 Oct 1969
REGISTRAR'S SIGNATURE Wayne R. Zieskari

25. EMBALMER Donald Ward
LICENSE NO. E-330
FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 27 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4810
Local Reg. No. 120
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy 177
c. LENGTH OF STAY (in this place) 1892
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 2900
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) Alfred c. (Last) Sandell

4. DATE OF DEATH: (Month) Oct (Day) 14 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept 30, 1886

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone owner 22

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Sweden

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew Sandell — BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Ingalena Johnson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-01-8671

17. INFORMANT'S OWN SIGNATURE: W. Dale McGahan — ADDRESS: Troy, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4389

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-18, 1950, *to* 8-14, 1969, *that I last saw the deceased alive on* 8-14, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Omer H Drury 148 (Degree or title) MD

23b. ADDRESS: Troy Idaho

23c. DATE SIGNED: 10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct 18, 1969

24c. NAME OF CEMETERY OR CREMATORY: Burnt Ridge Cemetery

24d. LOCATION (City, town, or county) (State): near Troy Idaho

DATE REC'D BY LOCAL REG.: 10-23-69

REGISTRAR'S SIGNATURE: Dolores Lettenmaier (Deputy)

25. EMBALMER: Donald Ward — LICENSE NO.: E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 27 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4811
Local Reg. No. 119
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 2 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 403 North Monroe

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 403 North Monroe

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lena	Louise	Paluthe	Oct. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	May 7, 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	LaCrosse, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Entel	Germany	Addie unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			X Anna Marie Redinger	Colton, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4121 Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Essential Hypertension — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1965, to Oct, 1969, *that I last saw the deceased alive on* Sept 25, 1969, *and that death occurred at* [illegible] m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. R. Adams	MD	Moscow, Idaho	10/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 21, 1969	Moscow Catholic Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-23-69	Dolores Lettenmaier (Deputy)	E. Pete Halverson	E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 1 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED NOV 4 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4812
Local Reg. No. 121
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Juliaetta
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	EDGAR	LEANDER	LACKEY	19 October 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	26 Feb. 1918	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Logger 17	Lumbering	Kendrick, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Lackey	Oklahoma	Patsy Patty	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW-2 4	518 14 5702	x Irene Lackey	Juliaetta, Idaho

4812

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Superior Mesenteric artery — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Hypertension

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Bilateral Severe Polycystic Kidneys

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 10-19-, 1969, *to* 10-19, 1969 *that I last saw the deceased alive on* 10-19, 1969 *and that death occurred at* 7 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
x Lowell C. Volder 541	MD	Moscow Idaho	10-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	23 Oct 1969	Juliaetta Cemetery	Juliaetta, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-27-69	Dolores Lettenmaier Deputy	Donald Ward	E-386

FIRM NAME: SHORT'S CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 5 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 5 1988

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4813
Local Reg. No. 122
Reg. Dist. No. 200

RECEIVED NOV 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 40 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Paradise Villa Nursing Home 289

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 910 East 1st

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Jack	Francis	Mc Quade	October 22 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	April 14, 1909	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Judge 8
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Michael Joseph McQuade — BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Mary Farnan — BIRTHPLACE Snowline, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-36-1554
17. INFORMANT'S OWN SIGNATURE X Miles McQuade ADDRESS Moscow, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4709

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 16 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Previous myocardial infarction 19 years
Cerebral Sclerosis 9 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1958 *to* October, 1969, *that I last saw the deceased alive on* Oct 22, 1969, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE J. M. Myers M.D. (Degree or title)
23b. ADDRESS MOSCOW, IDAHO
23c. DATE SIGNED 10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-25-1969
24c. NAME OF CEMETERY OR CREMATORY Moscow Catholic Cemetery
24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 10-29-69
REGISTRAR'S SIGNATURE Dolores Littenmaier (Deputy)
25. EMBALMER E. Pete Alberson — LICENSE NO. E-525
FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: NOV 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4814
Local Reg. No. 123
Reg. Dist. No. 200

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN Moscow
c. LENGTH OF STAY (in this place) 5 Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN Rural
d. STREET ADDRESS (If rural, give location) 4 miles North of Potlatch

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DORA	ALICE	MCKOWN	October 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	September 4, 1878	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Kansas	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles E. Short	New York	Lola Scriptur	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	534-38-2378	Lester McKown	Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Acute Myocardial Infarction — Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congestive Heart Failure — yes.

DUE TO (c) Arteriosclerotic Heart Dis — yes.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 64, *to* Dec 23, 19 69, *that I last saw the deceased alive on* Dec 18, 19 69, *and that death occurred at* 6:20 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Brooks 058 MD	Moscow, Idaho	10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-27-69	Freeze Cemetery	Latah County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-30-69	Dolores Letterman (Deputy)	E. A. Kimball	1260

FIRM NAME: Kimball Funeral Home, Palouse, Wa. 99161

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 16 1991

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4815
Local Reg. No. 124
Reg. Dist. No. 200

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 40 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 304 E. A St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 304 E. A St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Sarah	Louise	Graue		Oct	31	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	married	July 15, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sioux Falls, S.D.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William L. Baker — BIRTHPLACE: N.Y.
14. MOTHER'S MAIDEN NAME: Sarah Wiswall — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-46-6879B
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis
DUE TO (c) Degenerative Cerebrovascular 20 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension for years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ~~Nov~~ Oct 33, to 10-31-1969, that I last saw the deceased alive on [illegible], 19 [illegible] and that death occurred at 7:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Joseph D. Wilson MD		Moscow Idaho	11-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Cremation	Oct 31, 1969	Ball & Dodd	Spokane	Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
5 Nov 1969	Wayne R Heiskari	not embalmed	

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

MAR 17 1970

DEC 01 2008

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Found dead in Bed by Husband died in Sleep. Cause uncertain. Probably a stroke or acute coronary.

State File No. 4816
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 300 Lemhi OCT 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
c. LENGTH OF STAY (in this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Steele Mem. Hospital 47

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Butte 120
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Arco
d. STREET ADDRESS (If rural, give location) Rt.1, Box 10, County Road

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) NELSON
c. (Last) STIFFLER

4. DATE OF DEATH (Month) (Day) (Year) October 11, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 1, 1934
9. AGE (In years last birthday) 35 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Laborer
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Gooding, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Donald Lee Stiffler — BIRTHPLACE Unobtainable
14. MOTHER'S MAIDEN NAME Sylvia DeMain — BIRTHPLACE Cascade, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-34-2717
17. INFORMANT'S OWN SIGNATURE Shirley Stiffler — ADDRESS Arco, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9229

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gun Shot wound — INTERVAL BETWEEN ONSET AND DEATH: One hour

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Near Mag Idaho 31
21c. (CITY, TOWN, OR TOWNSHIP) Imry 13190 (COUNTY) Custer (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 11 1969 5:30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Accidental gun shot

22. *I hereby certify that I attended the deceased from* pleasant arrival, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 4:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE Roy Lindau M.D. 474 (Degree or title)
23b. ADDRESS Salmon Idaho
23c. DATE SIGNED Oct 17-1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE 10-15-69
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Arco, Idaho (State)

DATE REC'D BY LOCAL REG. Oct 28-1969
REGISTRAR'S SIGNATURE Viola E. Johnson
25. EMBALMER Gilbert C Jones
LICENSE NO. E 369

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Jones Funeral Home, Salmon

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4817
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Lemhi 302 OCT 30 1969
b. CITY OR TOWN: Salmon
c. LENGTH OF STAY (In this place): 15 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casabello Estate 272

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 302
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elijah	none	Jones	Oct. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Jan. 26, 1886	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ranch laborer 64		Tennessee	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eugene F. Jones	unknown	Minnie C. Unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	528-50-0157A	Glen M. Winkelblack D	Salmon, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardiac Decompensation	1 yr.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Myocardial Degeneration	2 yrs.
DUE TO (c)	Arteriosclerosis generalized	10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 1957, *to* 10-18, 1969, *that I last saw the deceased alive on* 10-6, 1969, *and that death occurred at* 5:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M Moore 369 Title	Salmon Idaho	10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 20, 1969	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 28-1969	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4818
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

RECEIVED
OCT 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give name of township): Salmon
c. LENGTH OF STAY (In this place): 1½ month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) Priscilla c. (Last) Centaurus

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 27, 1893

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bullion, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Walker
BIRTHPLACE: Wisc.

14. MOTHER'S MAIDEN NAME: Ellen Agnes Bohren
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-32-9362B

17. INFORMANT'S OWN SIGNATURE: Will Centaurus
ADDRESS: Challis

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4122

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) {Hypertension / Generalized arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Kidney failure

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-9-60, 19____, *to* 10-21-, 19 69, *that I last saw the deceased alive on* 10-21, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 263
(Degree or title): MD

23b. ADDRESS: Box 769 Salmon, Idaho 83467

23c. DATE SIGNED: 10-23

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 24, 1969

24c. NAME OF CEMETERY OR CREMATORY: Challis

24d. LOCATION (City, town, or county) (State): Challis, Idaho

DATE REC'D BY LOCAL REG.: Oct 28 1969

REGISTRAR'S SIGNATURE: Viola E. Johnson

25. EMBALMER: Delbert C. Jones

LICENSE NO.: E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4819
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

OCT 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (If hospital or institution, give street address or location): 46 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): Charles
c. (Last): Owens

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct. 27, 1883
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Power Plant operator, 08
10b. KIND OF BUSINESS OR INDUSTRY: retired, Idaho Power
11. BIRTHPLACE (State or foreign country): Fort Pierre, So. Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jesse S. Owens
BIRTHPLACE: So. Dakota
14. MOTHER'S MAIDEN NAME: Hulda Laure Brakka
BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-07-2763
17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: Salmon, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 19 69, 1969, *to* Oct 21, 1969, *that I last saw the deceased alive on* Oct 21, 1969, *and that death occurred at* 12 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 474 MD
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 10-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-23-69
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Oct 28th 69
REGISTRAR'S SIGNATURE: Viola E Johnson
25. EMBALMER: Delbert C Jones
LICENSE NO.: E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: JONES FUNERAL HOME

DUTIES:

DEC 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4820
Local Reg. No. [redacted] 1
Reg. Dist. No. 737

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Lewis 310 OCT 9 1969
b. CITY OR TOWN Craigmont
c. LENGTH OF STAY (in this place) 7 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION own home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lewis 310
c. CITY OR TOWN Craigmont
d. STREET ADDRESS (If rural, give location) 415 Ransdell Rd.

3. NAME OF DECEASED (Type or Print) a. (First) Gertrude b. (Middle) E. c. (Last) Snyder

4. DATE OF DEATH (Month) (Day) (Year) Oct. 4 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH March 9, 1896

9. AGE (In years last birthday) 73
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cowgill, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME M. D. L. Blevins BIRTHPLACE Mo.

14. MOTHER'S MAIDEN NAME Louisa Josephine Myers BIRTHPLACE MO.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 18 2702

17. INFORMANT'S OWN SIGNATURE x E. E. Snyder ADDRESS Craigmont, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Coronary occlusion with myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1968, to _____, 19___, *that I last saw the deceased alive on* 9-27, 1969, *and that death occurred at* 6 Am., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD 310

23b. ADDRESS 628 5th Ave. Lewiston

23c. DATE SIGNED 10/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE 10-7-69

24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery

24d. LOCATION (City, town, or county) (State) Craigmont, Idaho

DATE REC'D BY LOCAL REG. 10-8-69

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER Cletus Uhlorn

LICENSE NO. E421

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4821
Local Reg. No. 670
Reg. Dist. No. 430

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

OCT 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richfield Rural
c. LENGTH OF STAY (in this place): yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ranch Home 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richfield Rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): URBAN
b. (Middle): J.
c. (Last): MASON, SR.

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: July 2, 1907
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months 3, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Vanduser, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Mason — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Ida Armentia Joyce — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 486-18-3988
17. INFORMANT'S OWN SIGNATURE: X Urban J Mason Jr — ADDRESS: Shelley, Ida.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes Mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive, *19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 1100 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature], Coroner 583 (Degree or title) 4
23b. ADDRESS: Box 68 Shoshone Idaho
23c. DATE SIGNED: Oct 9 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 10-10-1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Shelley, Idaho

DATE REC'D BY LOCAL REG.: 10-11-69
REGISTRAR'S SIGNATURE: Francis M Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 15 1969

OCT 14 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4822
Local Reg. No. 671
Reg. Dist. No. 4130

RECEIVED
OCT 27 1969
Bureau of Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone Rural
LENGTH OF STAY IN (this place): 27 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone Rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
PEARL	J.	BLACKWOOD	Oct.	18,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Nov. 7, 1895	73	11	11		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Perry P. Blackwood — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary Evans — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 519-09-9792
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see him, 19__, to __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 3 noon *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title) Coroner
23b. ADDRESS: Box 68 Rockford Idaho
23c. DATE SIGNED: Oct 22 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-23-1969
24c. NAME OF CEMETERY OR CREMATORY: Blackfoot Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: 10-24-69
REGISTRAR'S SIGNATURE: Frances M Bergin
25. EMBALMER: Frances M. Bergin
LICENSE NO.: E-463
FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 28 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 7 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4823
Local Reg. No.
Reg. Dist. No.

RECEIVED NOV 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 320 Lincoln
b. CITY OR TOWN Shoshone
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 240 WoodRiver Convalescent

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 070 Blaine
c. CITY OR TOWN Hailey
d. STREET ADDRESS (If rural, give location) 416 South Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CARROLL	MELROY	FOLEY	Oct. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	July 16, 1888	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ranch, Forest 04		Giard, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomithy Foley	Irland	UNK	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW 1 3	518-09-4758	Esther M Foley	Hailey, Idaho

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 24, 1969, *to* Oct 31, 1969, *that I last saw the deceased alive on* Oct 24, 1969, *and that death occurred at* 11:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M Peterson 386	Box 68 Shoshone Idaho	11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11/4/69	Hailey Cemetery	Hailey, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Francis M. Bergin	Keith Bird Keith Bird	E-373

FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4824
Local Reg. No. 62
Reg. Dist. No. 630

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331 — OCT 13 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 330
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Thornton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Walker
b. (Middle): William
c. (Last): Lyman

4. DATE OF DEATH (Month) (Day) (Year): Oct. 4, 1969

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 10, 1915
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager Potatoe Warehouse 26
10b. KIND OF BUSINESS OR INDUSTRY: Potatoe Warehouse
11. BIRTHPLACE (State or foreign country): Thornton, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Christen Lyman — BIRTHPLACE: Hyrum, Utah
14. MOTHER'S MAIDEN NAME: Sarafina P.C.Ploerer — BIRTHPLACE: Chicago, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-10-8966
17. INFORMANT'S OWN SIGNATURE: x Brent J Lyman — ADDRESS: Rt #2 Box 114 Rigby

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Thrombosis~~ Thrombus, recent, anterior descending branch,

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (2) coronary artery.
DUE TO (c) (2) Coronary Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 746 I Mitchell M.D.
23b. ADDRESS: L.D.S. Hosp. Idaho Falls, Idaho
23c. DATE SIGNED: 10/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/7/69
24c. NAME OF CEMETERY OR CREMATORY: Sutton Cemetery
24d. LOCATION (City, town, or county) (State): Archer, Madison, Idaho

DATE REC'D BY LOCAL REG.: 10-8-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Russel F Flamm
LICENSE NO.: E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4825
Local Reg. No. 63
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 20 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 330
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Plano
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 330
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg Rt 2 Plano
d. STREET ADDRESS (If rural, give location): Rexburg RFD 2

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Alfred
c. (Last): Hillman

4. DATE OF DEATH (Month) (Day) (Year): Oct. 11, 1969

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct.15,1894
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Rancher Stockman 04
10b. KIND OF BUSINESS OR INDUSTRY: Cattle raising
11. BIRTHPLACE (State or foreign country): Plano, Madison County, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mayhew Hillman — BIRTHPLACE: Fort Harrison, Utah
14. MOTHER'S MAIDEN NAME: Elizabeth Atkinson — BIRTHPLACE: Mendon, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-42-8055 A
17. INFORMANT'S OWN SIGNATURE: x Eveline Hillman — ADDRESS: Rexburg RFD 2

18. CAUSE OF DEATH 4409
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral anoxia	1 day
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Generalized arteriosclerosis	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Cardiac decompensation	1 year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar. 26, 1965, *to* Oct. 11, 1969, *that I last saw the deceased alive on* Oct. 10, 1969, *and that death occurred at* 2:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): AC Truxal, M.D. 537
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/14/69
24c. NAME OF CEMETERY OR CREMATORY: Plano Cemetery
24d. LOCATION (City, town, or county) (State): Plano, Madison, Idaho

DATE REC'D BY LOCAL REG.: 10-14-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: James R Flamm — LICENSE NO. E-477

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 27 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4826
Local Reg. No. 64
Reg. Dist. No. 630

BIRTH NO.

RECEIVED OCT 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison (33)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 445 West Main

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison (33)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 445 West Main

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VERA	B	KAUER	October 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	April 10, 1930	39				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rexburg, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ernest Ferdinand Kauer	Bern, Switzerland	Rosalie Karoline Beck Wurtemberg	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: x Pauline K. Bird ADDRESS: Rexburg, Idah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congenital Heart Disease — same birth
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mongolism — same birth

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-1, 1968, *to* 10-12, 1969, *that I last saw the deceased alive on* 10-12, 1969, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lester J Peterson MD	Rexburg, Idaho	10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/15/69	Burton	Madison County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-14-69	Leona Flamm	Kenneth Flamm	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 21 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 23 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4827
Local Reg. No. 65
Reg. Dist. No. 6 30

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

OCT 30 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics): Rexburg
c. LENGTH OF [illegible] (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rexburg Nursing Home 307

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 55 E 1 No.

3. NAME OF DECEASED (Type or Print)
a. (First): Albert
b. (Middle): Henry
c. (Last): Brian

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1969

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 20, 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Millcreek, Utah
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Danial Gross Brian — BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Martha Elizabeth Ashworth — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-30-2588
17. INFORMANT'S OWN SIGNATURE: Henry E Brian — ADDRESS: 55E1N. Rexburg, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility — INTERVAL BETWEEN ONSET AND DEATH: Two years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized

DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct., 1949, *to* Oct 18, 1969, *that I last saw the deceased alive on* Oct 10, 1969, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. F. Rigby Mod. 442
23b. ADDRESS: Rexburg
23c. DATE SIGNED: 10-20-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/21/69
24c. NAME OF CEMETERY OR CREMATORY: Rexburg
24d. LOCATION (City, town, or county) (State): Rexburg, Madison, Idaho

DATE REC'D BY LOCAL REG.: 10-21-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Russel Flamm
LICENSE NO.: E-254

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 31 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4828 66
Local Reg. No.
Reg. Dist. No. 6 3 0

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 331 Madison — OCT 3 0 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison 330
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First) Peter
b. (Middle) Jeppesen
c. (Last) Ricks

4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1969

5. SEX Male

6. COLOR OR RACE Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 16, 1886

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY 04

11. BIRTHPLACE (State or foreign country) Rexburg, Idaho

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Ricks
BIRTHPLACE Farmington, Utah

14. MOTHER'S MAIDEN NAME Sophia Nelson Jeppesen
BIRTHPLACE Siebbjerg, Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-36-0724A

17. INFORMANT'S OWN SIGNATURE Mark D. Ricks
ADDRESS Rexburg Rt. 1 Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Nephritis
DUE TO (c) Secondary Anemia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1940, to Oct. 21, 1969, *that I last saw the deceased alive on* Oct. 21, 1969, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D. 442

23b. ADDRESS Rexburg Idaho

23c. DATE SIGNED Oct 22 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/24/69

24c. NAME OF CEMETERY OR CREMATORY Sutton Cemetery

24d. LOCATION (City, town, or county) (State) Archer, Madison, Idaho

DATE REC'D BY LOCAL REG. 10-24-69

REGISTRAR'S SIGNATURE Leona Flamm

25. EMBALMER Russel Flamm
LICENSE NO. E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4829
Local Reg. No. 67
Reg. Dist. No. 6 30

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 331 Madison — OCT 3 0 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg — c. LENGTH OF STAY (In this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) 250 N 3 East

3. NAME OF DECEASED (Type or Print) — a. (First) Caleb — b. (Middle) Victor — c. (Last) Anderson Jr.

4. DATE OF DEATH (Month) (Day) (Year) Oct. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caus.	Married	Oct. 9, 1910	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rexburg, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME — BIRTHPLACE: Caleb Victor Anderson — Lehi, Utah
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Barbara Spence Leatham — Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-14-8570
17. INFORMANT'S OWN SIGNATURE Billie Madison — ADDRESS Rexburg 250 N3 E

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5719

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic active hepatitis with cirrhosis — INTERVAL BETWEEN ONSET AND DEATH several yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1964, *to* 10-25, 1969, *that I last saw the deceased alive on* 10-25, 1969, *and that death occurred at* 2 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Victor J Anderson 413 (Degree or title) MD
23b. ADDRESS Rexburg, Idaho
23c. DATE SIGNED 10-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/28/69
24c. NAME OF CEMETERY OR CREMATORY Teton- Newdale Cemetery
24d. LOCATION (City, town, or county) Teton, Madison, (State) Idaho

DATE REC'D BY LOCAL REG. 10-28-69
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER Russell Flamm — LICENSE NO. E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 3 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 1 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Dalley

Certificate of Death

STATE OF IDAHO

State File No. 4830
Local Reg. No. 74
Reg. Dist. No. 450

BIRTH NO.

RECEIVED OCT 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 5 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 325

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 813 8th street

3. NAME OF DECEASED (Type or Print)
a. (First) Dorothea
b. (Middle)
c. (Last) Dietz

4. DATE OF DEATH (Month) (Day) (Year) October 3-69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Sept 27 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife
10b. KIND OF BUSINESS OR INDUSTRY 0/
11. BIRTHPLACE (State or foreign country) Zeeland North Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Rutschke — BIRTHPLACE Russia
14. MOTHER'S MAIDEN NAME Anna Munch — BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-60-8881
17. INFORMANT'S OWN SIGNATURE x Bernhard A. Dietz ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH few days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriasclerosis — many years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes mellitis — 5 yrs
Degenerative arthritis with osteoporosis — many years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* Feb. 11, 1960, *to* Oct 3, 1969, *that I last saw the deceased alive on* Oct 3, 1969, *and that death occurred at* 4:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE C E Dalley (Degree or title) M D
23b. ADDRESS 702 G Street Rupert, Idaho
23c. DATE SIGNED 10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 7 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 10-21-69
REGISTRAR'S SIGNATURE Mary Ellen Barlow
25. EMBALMER Charles D Parsons — LICENSE NO. E-494
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Dalley -

Certificate of Death

STATE OF IDAHO

State File No. 4831
Local Reg. No. 75
Reg. Dist. No. 450

BIRTH NO.

RECEIVED OCT 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
LENGTH OF STAY (in this place) 11 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 723 6th street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	David	135	Klauser	Oct 5 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Mar 21 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Wymar Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Klauser — BIRTHPLACE: New Wymar Russia
14. MOTHER'S MAIDEN NAME: Mary Weimer — BIRTHPLACE: New wymar Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO. 518-42-7113
17. INFORMANT'S OWN SIGNATURE: A Wm Klauser — ADDRESS: Rupert

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: few days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized severe degenerative (gouty) arthritis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 9, 1957, *to* Oct 5, 1969, *that I last saw the deceased alive on* Oct 5, 1969, *and that death occurred at* 10:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: C F Dalley M D (Degree or title)
23b. ADDRESS: 702 B St Rupert Idaho
23c. DATE SIGNED: 10/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 9 1969
24c. NAME OF CEMETERY OR CREMATORY: Paul Cemetery
24d. LOCATION (City, town, or county) (State): Paul Idaho

DATE REC'D BY LOCAL REG.: 10-21-69
REGISTRAR'S SIGNATURE: Mary Ellen Barbour
25. EMBALMER: Charles H Peterson
LICENSE NO.: E-474
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Jan 30, 1970

Certificate of Death
STATE OF IDAHO

State File No. 4832
Local Reg. No. 76
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (In this place):
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Harry; b. (Middle) Burns; c. (Last) Colwell

4. DATE OF DEATH: (Month) October (Day) 16, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept 29, 1884

9. AGE (In years last birthday): 85
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postmaster (Retired) 23

10b. KIND OF BUSINESS OR INDUSTRY: Postal Service

11. BIRTHPLACE (State or foreign country): Stark County, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Perley B. Colwell
BIRTHPLACE: Stark Co., Ill.

14. MOTHER'S MAIDEN NAME: Marian Cecilia Burns
BIRTHPLACE: Peoria, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 518-40-8846A

17. INFORMANT'S OWN SIGNATURE: Chas. B. Colwell
ADDRESS: Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4412

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Ruptured abdominal aneurysm
INTERVAL BETWEEN ONSET AND DEATH: 6 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis, generalized
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: General debility of age

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1966, *to* 16 Oct, 1969, *that I last saw the deceased alive on* 16 Oct, 1969, *and that death occurred at* 3:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. W. Crawford, M.D. 740 (Degree or title)
23b. ADDRESS: Rupert, Idaho
23c. DATE SIGNED: 17 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct 18, 1969
24c. NAME OF CEMETERY OR CREMATORY: Wyoming Cemetery
24d. LOCATION (City, town, or county) (State): Wyoming, Stark County, Ill.

DATE REC'D BY LOCAL REG.: 10-21-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Robert C. Walk
LICENSE NO.: E 294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED

JAN 23 1970

Bureau of Vital Statistics

State of Idaho } ss.
County of Minidoka

Certificate No. 69-4832

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death) for Harry Colwell (Name on Original Certificate) who died (Was Born or Died) on Oct 16, 1969 (Date of Event) in Rupert, Idaho (Place of Event) are erroneous or were omitted, and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#3 Name of Deceased	Harry Colwell	Harry Burns Colwell
#13 Father Name & Birthplace	Unknown	Perley B.Colwell.Stark Co.,
#14 Mother's Name & Birthplace	Unknown	Marion Cecilia Burns Ill.
		Stark Co. Ill. Peoria

Subscribed and sworn to before me this 22nd day of January, 1970

Notary Public, residing at Rupert Idaho

My commission expires Sept 28, 1970

(Seal)

Signed [signature]

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Nox 8, Rupert, Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Minidoka

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 22nd day of January, 1970

Notary Public, residing at Rupert Idaho

My commission expires Jan 1, 1971

(Seal)

Signed Mildred Hyde

(Signature of Any Credible Person)

1007 7th St, Rupert, Idaho

(Street Address, City, State)

FORM DH 60-155

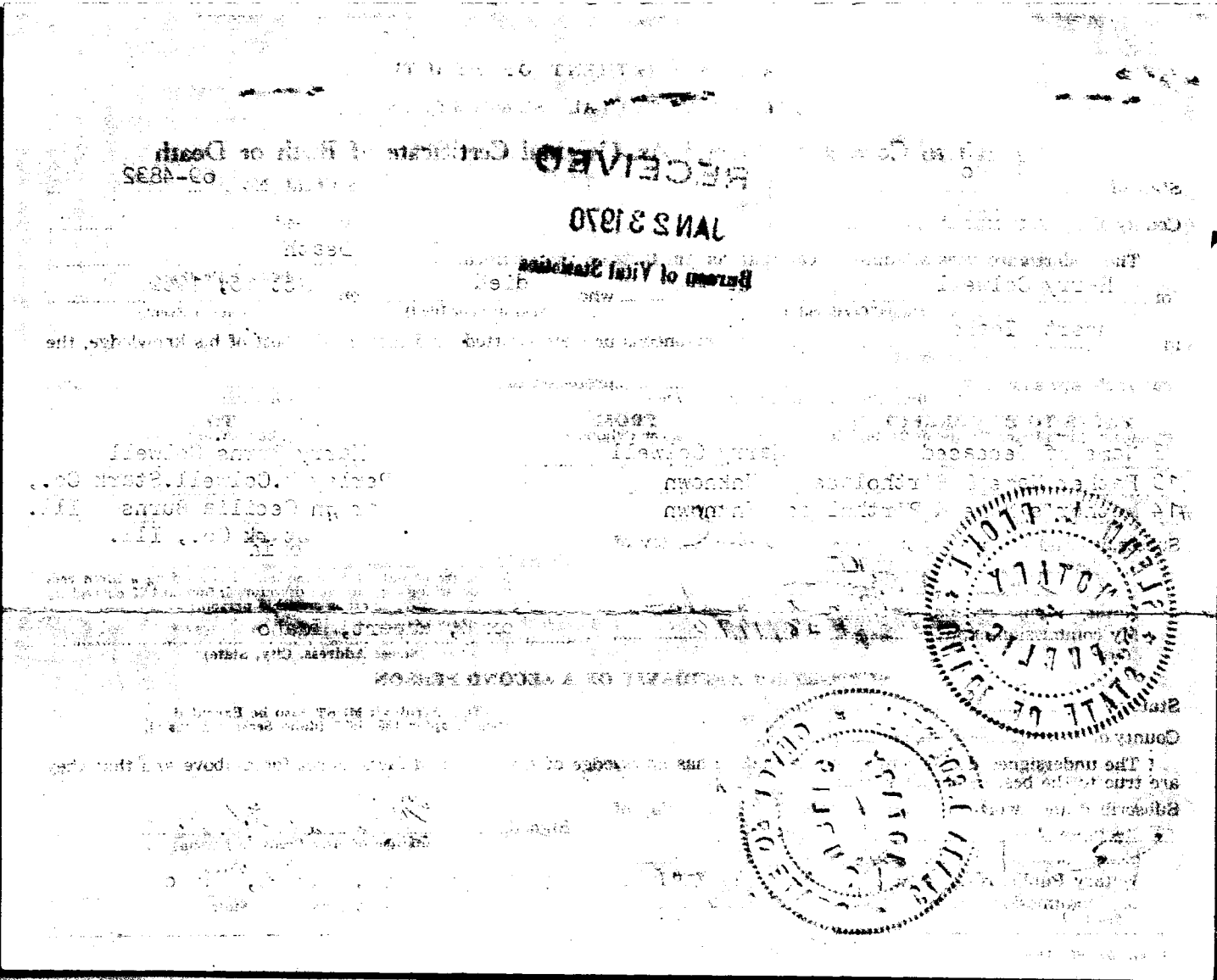

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4832
Local Reg. No. 76
Reg. Dist. No. 450

RECEIVED OCT 22 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): HARRY
b. (Middle):
c. (Last): COLWELL

4. DATE OF DEATH (Month) (Day) (Year): October 16, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 29, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postmaster (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Postal Service
11. BIRTHPLACE (State or foreign country): Stark County, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - - -
16. SOCIAL SECURITY NO.: 518-40-8846-A
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Rupert, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4412

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured abdominal aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 6 Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis, generalized.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. General debility of age.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1966, *to* 16 Oct, 1969, *that I last saw the deceased alive on* 16 Oct, 1969, *and that death occurred at* 3:15 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. W. Crawford MD
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 17 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Oct. 18, 1969
24c. NAME OF CEMETERY OR CREMATORY: Wyoming Cemetery
24d. LOCATION (City, town, or county) (State): Wyoming, Stark County, Ill.

DATE REC'D BY LOCAL REG.: 10-21-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Robert C Walk — LICENSE NO. E 294

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

NOV 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 28 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4833
Local Reg. No. 77
Reg. Dist. No. 450

BIRTH NO.

RECEIVED OCT 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN: Rupert
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN: Rupert
d. STREET ADDRESS (If rural, give location): (Grandview Addn) 17th Street 125

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HORACE	M.	HATCH	October 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	February 1, 1911	58				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment Operator 66
10b. KIND OF BUSINESS OR INDUSTRY: Amalgamated Sugar Company
11. BIRTHPLACE (State or foreign country): Woods Cross, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John I. Hatch - BIRTHPLACE: Woods Cross, Utah
14. MOTHER'S MAIDEN NAME: Ida Luella Moss - BIRTHPLACE: Woods Cross, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-24-5111
17. INFORMANT'S OWN SIGNATURE: + Afton Hatch — ADDRESS: Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* 16 Oct, 1969, *and that death occurred at* 8:50A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. W. Crawford 340	M.D	Rupert Idaho	21 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 20, 1969	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-21-69	Mary Ellen Carlson	Charles H Parsons	E-494

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 29 1969

JUL 9 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4834
Local Reg. No. 78
Reg. Dist. No. 4-10

BIRTH NO. 69-10571

RECEIVED
Bureau of Vital Statistics
OCT 27 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka (340)
b. CITY OR TOWN: Rupert
c. LENGTH OF STAY IN THIS PLACE: Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka (340)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	Deon	Verdel	Moss

4. DATE OF DEATH: (Month) Oct. (Day) 18, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Never Married	Oct. 18, 1969	–	–	–	–	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rupert, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lendon H. Moss, BIRTHPLACE: New Dale, Idaho
14. MOTHER'S MAIDEN NAME: Ramona Leola Owens, BIRTHPLACE: American Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): – – – –
16. SOCIAL SECURITY NO. – – – –
17. INFORMANT'S OWN SIGNATURE: Lendon H. Moss ADDRESS: 105 So 5th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prolapse of umbilical cord at delivery. Version and
DUE TO (c) extraction for delivery.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 Oct, 1969, *to* 18 Oct, 1969, *that I last saw the deceased alive on* 18 Oct, 1969, *and that death occurred at* 5:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. W. Crawford (Degree or title) MD
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 21 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Oct. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: 10-24-69
REGISTRAR'S SIGNATURE: Mary Ellen Graham
25. EMBALMER: Ormand F. Burch
LICENSE NO.: E-471
FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: SEP 5 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4835
Local Reg. No. 39
Reg. Dist. No. 450

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340 NOV 4 1969
b. CITY OR TOWN Rupert
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul (rural)
d. STREET ADDRESS (If rural, give location) 546 West - 200 North (Rt #1)

3. NAME OF DECEASED (Type or Print) a. (First) Fred b. (Middle) Fortunato c. (Last) FONTANARI

4. DATE OF DEATH (Month) (Day) (Year) Oct. 23, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH July 18, 1895

9. AGE (In years last birthday) 74 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Hand (retired)

10b. KIND OF BUSINESS OR INDUSTRY U.P.Railroad

11. BIRTHPLACE (State or foreign country) San Torsala, Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown Fontanari — BIRTHPLACE Italy

14. MOTHER'S MAIDEN NAME unknown — BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — — —

16. SOCIAL SECURITY NO. 721-14-2674

17. INFORMANT'S OWN SIGNATURE Aldo L Dallolio — ADDRESS Rt #1 Paul

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized degenerative changes of advanced years. — INTERVAL BETWEEN ONSET AND DEATH: many years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — many years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bilateral Pulmonary Tuberculosis — many years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* Oct 23, 1969, *and that death occurred at* 2:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE A Z Dalley 127 (Degree or title) MD

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct.25,1969

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) Rupert, Idaho (State)

DATE REC'D BY LOCAL REG. 10-31-69

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Charles L. Peterson

LICENSE NO. E-494

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4836
Local Reg. No. 81
Reg. Dist. No. 4570

1. PLACE OF DEATH
a. COUNTY Minidoka MINIDOKA 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 23 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Minidoka Memorial Hospital 725

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	August	C.	Lange	Oct 24 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Aug 21 1895	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ellsworth Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Herman Lange — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Augusta Trapp — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-42-1858A
17. INFORMANT'S OWN SIGNATURE x Mrs Ida Lange ADDRESS Rt 1 Rupert Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriolar sclerosis. — not known

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 17, 1961, *to* Oct. 24, 1969, *that I last saw the deceased alive on* Oct 24, 1969, *and that death occurred at* 7:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O F Dalley M D 127	702 S Rupert Idaho	Oct 29, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 28 1969	Rupert Cemetery	Rupert Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-31-69	Mary Ellen Carlson	Robert A Walk	E294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: NOV 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4837
Local Reg. No. 80
Reg. Dist. No. 450

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Minidoka 340 NOV 4 1969
b. CITY OR TOWN Rupert
c. LENGTH OF STAY (If this place) 135
d. FULL NAME OF HOSPITAL OR INSTITUTION Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul (rural)
d. STREET ADDRESS (If rural, give location) 1275 West - 050 South (Rt. 1)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Betty	B	WARREN	October 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Sept. 16, 1918	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Onw Home	Plainview, Texas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Omer E. Elliott	Oklahoma	Bess D. Vines	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— — —		Willard Warren	Rt. 1, Paul, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Astrocytoma, at frontal lobe — INTERVAL BETWEEN ONSET AND DEATH: 13 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Last operated Dec. 1966 — diagnosis reconfirmed	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov, 1955, *to* 29 Oct, 1969, *that I last saw the deceased alive on* 29 Oct, 1969, *and that death occurred at* 8:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. W Crawford 340	MD	Rupert Idaho	30 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 1, 1969	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-31-69	Mary Ellen Carlson	Robert C Walk	E 294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4838
Local Reg. No. 283
Reg. Dist. No. 220

RECEIVED NOV 17 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 351
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): Upper Tammany

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): EDWARD
c. (Last): THIESSEN

4. DATE OF DEATH (Month) (Day) (Year): 23 Sept 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 5 Dec. 1898
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Stock & Grain
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Gus D. Thiessen — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Mary Wasem — BIRTHPLACE: Eagle Co., Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW- 3
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs. August D. Thiessen — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 mo.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: None.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): No injury m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 20, 1969, *to* Sept 23, 1969, *that I last saw the deceased alive on* June 20, 1969 *and that death occurred at* 7 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph E. Boedeker, M.D.
23b. ADDRESS: 1522 [illegible] St.
23c. DATE SIGNED: 11/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 25 Sept 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-10-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in-charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4839
Local Reg. No. 367
Reg. Dist. No. 220

BIRTH NO.

RECEIVED OCT 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 908-7th Ave 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 908-7th Ave

3. NAME OF DECEASED (Type or Print)
a. (First): Midge
b. (Middle): L.
c. (Last): Cherrier

4. DATE OF DEATH (Month) (Day) (Year): Oct 2, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec 19, 1885
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Memphis, Missouri.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Smith — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Almira Gordon — BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): nO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-36-4915
17. INFORMANT'S OWN SIGNATURE: + Mrs E. R. Gibson — ADDRESS: Boulder, Colo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4121

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease. — Syn
DUE TO (c) Hypertension.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1968, *to* ____, 19__, *that I last saw the deceased alive on* Sept 26, 1969, *and that death occurred at* 450 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 020
23b. ADDRESS: 625 6th Ave Lewiston Idaho
23c. DATE SIGNED: Oct 6 - 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 10-10-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: V. Vassar
LICENSE NO.: E 297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4840
Local Reg. No. 262
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 351 — OCT 13 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KEWISTON
c. LENGTH OF [illegible] (If not in hospital or institution, give street address or location): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPHS HOSPITAL 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: WASHINGTON 48
b. COUNTY: ASOTIN 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CLARKSTON
d. STREET ADDRESS (If rural, give location): 1016 LIBBY

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): (NMI)
c. (Last): SEATZ

4. DATE OF DEATH (Month) (Day) (Year): Oct. 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: August 7, 1881
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cert. Public Accountant 17
10b. KIND OF BUSINESS OR INDUSTRY: Craig Lumber Co.
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE
14. MOTHER'S MAIDEN NAME — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-03-0671
17. INFORMANT'S OWN SIGNATURE: Hazel Seatz — ADDRESS: Clarkston, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: PULMONARY EMPHYSEMA — yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1959, *to* Oct 3, 1969, *that I last saw the deceased alive on* Oct 2, 1969, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 013 (Degree or title): MD
23b. ADDRESS: 307 St Johns Way
23c. DATE SIGNED: 10/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: Oct 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-10-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: WC Merchant
LICENSE NO.: FD 5

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Merchant Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 14 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 20 1976

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR - 9 1983

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4841
Local Reg. No. 263
Reg. Dist. No. 220

RECEIVED OCT 13 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35-1
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (At this place): 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nez Perce 35-1
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 711 1/2 - 10th Ave.

3. NAME OF DECEASED (Type or Print): a. (First) GLADYS b. (Middle) D. c. (Last) POWELL

4. DATE OF DEATH: (Month) (Day) (Year): 6 October 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: 1 Jan 1888

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Mercer County, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Coon
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Louisa Ragan
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 18 3119-T

17. INFORMANT'S OWN SIGNATURE: X Audra G. Smith
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Infirmities of age
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/10, 1967, to 10/6, 1969, that I last saw the deceased alive on 10/6, 1969, and that death occurred at 12 Noon m., from the causes and on the date stated above.

23a. SIGNATURE: R M Stover (Degree or title) MD
23b. ADDRESS: 939 Bryden Lewiston Ida
23c. DATE SIGNED: 10/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9 Oct 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-10-69
REGISTRAR'S SIGNATURE: Glenna Dalzen
25. EMBALMER: W E Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4842
Local Reg. No. 260
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 351 OCT 13 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
c. LENGTH OF STAY (If this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ORCHARDS NURSING HOME 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: NEZ PERCE 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
d. STREET ADDRESS (If rural, give location): 1014 BURRELL

3. NAME OF DECEASED (Type or Print)
a. (First): RAYMOND
b. (Middle): (NMI)
c. (Last): SKINNER

4. DATE OF DEATH (Month) (Day) (Year): 10/ 6/ 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: March 3, 1883
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Wheat
11. BIRTHPLACE (State or foreign country): ANATONE, WASHINGTON
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Skinner — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: (nfi) Fancler — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S OWN SIGNATURE: J. A. Skinner — ADDRESS: Rt. 2 Orofino, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

485X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Terminal Bronchopneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Infirmities of age
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-17, 1968, *to* 9/30, 1969, *that I last saw the deceased alive on* 9/30, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. M. Stover M.D.
23b. ADDRESS: 939 Bryden, Lewiston, Idaho
23c. DATE SIGNED: 10/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis - Clark Gardens
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-10-69
REGISTRAR'S SIGNATURE: Glenda Walzen
25. E. BALMER: M C Merchant
LICENSE NO.: FD 5

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Merchant Funeral Home Clarkston, Wn

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Barnes

State File No. 4843
Local Reg. No. 261
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Asotin 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 1481 Libby

3. NAME OF DECEASED (Type or Print)
a. (First): MINNIE
b. (Middle): L.
c. (Last): CHAMBERLIN

4. DATE OF DEATH (Month) (Day) (Year): Oct 7, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 25, 1911
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Nevada
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: William Gileson — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Margaret — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Fred Chamberlin — ADDRESS: 1481 Libby Clk, Wn

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Nephro Sclerosis — unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

403X

19a. DATE OF OPERATION: 9-29
19b. MAJOR FINDINGS OF OPERATION: Adeno Carcinoma Victorian
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-28, 1969, *to* 9-29, 1969, *that I last saw the deceased alive on* 9-29, 1969, *and that death occurred at* 12:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John F. Barnes M.D. 028
23b. ADDRESS: 347 St Johns Way Lewiston Idaho
23c. DATE SIGNED: 10-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 10, 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis - Clark Gardens
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-10-69
REGISTRAR'S SIGNATURE: Glenard Dalzen
25. EMBALMER: W C Merchant
LICENSE NO.: FD 5

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Merchant Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4844
Local Reg. No.
Reg. Dist. No.

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nezperce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2½ yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ferdinand
d. STREET ADDRESS (If rural, give location): Ferdinand

3. NAME OF DECEASED (Type or Print)
a. (First): JOSEPH
b. (Middle):
c. (Last): VEDDER

4. DATE OF DEATH (Month) (Day) (Year): Oct 7, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 16 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Cicinnatti, Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Rudolph Vedder — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Spanish American
16. SOCIAL SECURITY NO.: 515 20 1438 A
17. INFORMANT'S OWN SIGNATURE: X Wilfred R. Vedder — ADDRESS: Priest River, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiorespiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 1 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia — 6 days
DUE TO (c) Central arteriosclerosis — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility — 10 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 757 Walter W Seibling
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 10/11/69
24c. NAME OF CEMETERY OR CREMATORY: Ferdinand Cath. Cem
24d. LOCATION (City, town, or county) (State): Ferdinand, Idaho

DATE REC'D BY LOCAL REG.: OCT 22 1969
REGISTRAR'S SIGNATURE: W W Benson
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

OCT 23 1969
JUL 15 1982

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4845
Local Reg. No. 364
Reg. Dist. No. 220

BIRTH NO. OCT 20 1969

RECEIVED
Bureau of Vital Statistics
OCT 20 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: NezPerce 351

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1431-Airway 502

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: NezPerce 351

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

d. STREET ADDRESS (If rural, give location): 1431-Airway

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Margaret		Greco	Oct 8 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	Feb, 11, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chicago, Ill

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Anthony J. Schwegel	No record	Anna C. Hecker	Chicago, Ill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO. 335-03-6076

17. INFORMANT'S OWN SIGNATURE: Tony Greco ADDRESS: Lewiston, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular fibrillation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart disease.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypo-Thyroidism

INTERVAL BETWEEN ONSET AND DEATH

4123

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/26, 1951, *to* 10/8, 1969, *that I last saw the deceased alive on* 10-8-, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Don Stover MD 507	939 Bryden, Lewiston, Ida	10/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 11, 1969	Lewis-Clark Meroial Gardens	Lewiston, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-10-69	Elenara Walzen	Andrew F. Vassar	E315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 31 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4846
Local Reg. No. 270
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED OCT 27 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY NezPerce 35
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 10-6-69 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Josephs 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 611 - Preston Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Eva	Lena	Cox	October 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	3 October 1899	70	0	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	own home	Pendleton, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Snyder	Pennsylvania	Lena ???	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519-09-4099 B	Dean Cox	611 - Preston Ave.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus-Mild 7 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-7-69	Cystadenoma left ovary s implants about Sigmoid Colon & pelvic peritoneum. Adenocarcinoma Endometrium	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-2, 1962, *to* 10-11, 1969, *that I last saw the deceased alive on* 10-11, 1969, *and that death occurred at* 3:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ralph Dunn Jr MD 195			10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	13 Oct. 1969	Lewis-Clark Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-20-69	Glenna Dalzell	K.H. Malcom	E-376

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4847
Local Reg. No. 268
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH — OCT 27 1969
a. COUNTY NezPerce 35
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Josephs 128

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 615 - 3rd. Ave.

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Curtiss c. (Last) Burke
4. DATE OF DEATH (Month) (Day) (Year) October 14, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 23 November 1890
9. AGE (In years last birthday) 78 IF UNDER 1 YEAR Months 1 Days 9 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY self employed
11. BIRTHPLACE (State or foreign country) West Duluth, Minnesota
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas E. Burke BIRTHPLACE New York
14. MOTHER'S MAIDEN NAME Mollie Curtiss BIRTHPLACE unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-30-6177-A
17. INFORMANT'S OWN SIGNATURE Esther R. Burke (Wife) ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4442

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesenteric Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH 48 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized A.S. — year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary heart disease. — year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:10 AM, *from the causes and on the date stated above.*

23a. SIGNATURE C. S. Smyth M.D. (Degree or title)
23b. ADDRESS 307 St Johns Way, Lewiston, Ida
23c. DATE SIGNED 16 Oct '69

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE 16 Oct. 1969
24c. NAME OF CEMETERY OR CREMATORY Smiths Funeral Home
24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. 10-15-69
REGISTRAR'S SIGNATURE Alexander Walzer
25. EMBALMER L. E. DeBaun L. E. DeBaun
LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 27 1969 Bureau of Vital Statistics

State File No. 4848
Local Reg. No. 269
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 357
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): years

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 357
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence ooo
d. STREET ADDRESS (If rural, give location): 1121 Powers Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ALBERT	nmi	JOHNSON	15 October 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	10 June 1887	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Stock & Grain	Ness, Hollingdal, Norway	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Asle Kaaterud	Norway	Karai ? ?	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518 36 7817	Clarence L. Johnson	Lewiston, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Myocaraial Infarct — INTERVAL BETWEEN ONSET AND DEATH: moments

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* - - - - - -, 19- -, *to* - - - - - -, 19- -, *that I last saw the deceased alive on* - - - - - -, 19- -, *and that death occurred at* 4:00 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X [signature] Dep. Sheriff	Lewiston, Idaho	15 Oct 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	18 Oct 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-20-69	[signature]	W E Black	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4849
Local Reg. No. 271
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED OCT 27 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor Nursing Home 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3315 - 8th Street

3. NAME OF DECEASED (Type or Print)
a. (First): FRED
b. (Middle): JAMES
c. (Last): MOOERS

4. DATE OF DEATH (Month) (Day) (Year): 17 October 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 7 May 1877
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Stock & Grain
11. BIRTHPLACE (State or foreign country): Lake City, Calif.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charlie Mooers — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Emma ? — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 16 9422
17. INFORMANT'S OWN SIGNATURE: Myrtle J Harris — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchopneumonia & Cardiopulmonary failure — INTERVAL BETWEEN ONSET AND DEATH: 1 wk 1 day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Cerebral arteriosclerosis — 10 yrs

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1947, 19__ *to* 1969, 19__, *that I last saw the deceased alive on* 17 Oct 69, *and that death occurred at* 7:30 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Walter W Seitz Jr 757
23b. ADDRESS: Cag Dog Clk.
23c. DATE SIGNED: 21 Oct 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 20 Oct 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-23-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4850
Local Reg. No. 272
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 27 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewis-Clark Hotel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1523 'G' Street

3. NAME OF DECEASED (Type or Print)
a. (First): RAY
b. (Middle): CARL
c. (Last): MUNRO

4. DATE OF DEATH (Month) (Day) (Year): 19 October 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 26 Jul 1952
9. AGE (In years last birthday): 17 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bell Boy 06
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (State or foreign country): Anconda, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James A. Munro — BIRTHPLACE: Montana
14. MOTHER'S MAIDEN NAME: Marietta Currier — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 64 0044
17. INFORMANT'S OWN SIGNATURE: Marietta Munro — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9 18 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shock & Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Head and Body injuries
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): hotel bldg. 03
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Lewiston 13-051 NezPerce Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 19 Oct 1969 at 7:30 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Crushed between Elevator Carriage and Elevator Shaft.

22. *I hereby certify that I attended the deceased from* - - - - - - - *19* - - *to* - - - - - - - *19* - - *, that I last saw the deceased alive on* - - - - - - *19* - - *, and that death occurred at* 7:30 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duelos 583 4 (Degree or title): Coroner
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 21 Oct 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 23 Oct 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-23-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 1 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4851
Local Reg. No. 273
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 NOV 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF [illegible] (If [illegible] place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gifford
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): LOUIS
b. (Middle): HENRY
c. (Last): TIEDE

4. DATE OF DEATH (Month) (Day) (Year): 19 October 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 19 Feb 1899
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Stock & Grain
11. BIRTHPLACE (State or foreign country): Gifford, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Herman Tiede, Sr. — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Bertha Arndt — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Earl Tiede — ADDRESS: Gifford, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Myocardial Infarct

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-23-, 1966, *to* 9-23-, 1969, *that I last saw the deceased alive on* 9-23-, 1969, *and that death occurred at* 4:20PM *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 114 (Degree or title) [signature]
23b. ADDRESS: 347 St John Way
23c. DATE SIGNED: 10/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 22 Oct 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-24-69
REGISTRAR'S SIGNATURE: Glenara Walzer
25. EMBALMER: [signature] W E Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4852
Local Reg. No. 276
Reg. Dist. No. 220

RECEIVED
Bureau of Vital Statistics
NOV 4 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 357
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 7 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nezperce
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DAISY	nmi	LEITCH	21 October 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	13 Sept 1902	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Emida, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elwood B. Brown	Iowa	Sarrah K. Fink	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	no record	Daisy Leitch	Nezperce, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4123 CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) ARTERIOSCLEROSIS — yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. CEREBRAL VASCULAR DISEASE

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JAN 67, *to* OCT 21, 1969, *that I last saw the deceased alive on* 7/10, 1969, *and that death occurred at* 6:25 AM., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 013	MD	307 1st Johnson Way	10/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	24 Oct 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-28-69	[signature]	W E Black	E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 17 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4853
Local Reg. No. 277
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 — NOV 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics): Lewiston
c. LENGTH OF: 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 617 - 10th Street

3. NAME OF DECEASED (Type or Print)
a. (First): CORA
b. (Middle): ELLEN
c. (Last): NEDROW

4. DATE OF DEATH (Month) (Day) (Year): 22 October 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 16 April 1901
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Bartlesville, Okla.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Payton — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Anna May Wyatt — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No Record
17. INFORMANT'S OWN SIGNATURE: + Loretta M. Nance — ADDRESS: Spokane, Wn.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

575X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Stroke — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Acute Cholangitis — 2 months
DUE TO (c): Acute Gastric Ulcer — 1 week

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Muscular Dystrophy

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-29-68, 19__, *to* 10-22, 1969, *that I last saw the deceased alive on* 10-22, 1969, *and that death occurred at* 1 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 781 — **23b. ADDRESS**: Lewiston Idaho — **23c. DATE SIGNED**: 10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 25 Oct 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-28-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 24 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4854
Local Reg. No. 287
Reg. Dist. No. 220

RECEIVED NOV 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 351
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1920 Burrell Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): ANNA
b. (Middle): LAURA
c. (Last): SPARKS

4. DATE OF DEATH (Month) (Day) (Year): 23 October 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 19 January 1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Rosalia, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edgar Calhoun — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Rebecca Durham — BIRTHPLACE: Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 534 20 7196
17. INFORMANT'S OWN SIGNATURE: James H. Sparks — ADDRESS: Lewiston, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1829

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 16 hr

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Carcinoma Uterus c̄ Carcinomatosis — 15 yr
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Generalized Carcinomatosis
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 5:15 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 874
23b. ADDRESS: 678 5th Ave Lewiston Idaho
23c. DATE SIGNED: 10/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 27 Oct 1969
24c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Evergreen Cemetery
24d. LOCATION (City, town, or county) (State): Rosalia, Whitman Co., Wash.

DATE REC'D BY LOCAL REG.: 11-5-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 6 1988

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4855
Local Reg. No. 66
Reg. Dist. No. 210

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Nez Perce 357

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

c. LENGTH OF STAY IN (this place): few min.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St. Joseph's Hosp. 158

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Clearwater 180

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino

d. STREET ADDRESS (If rural, give location): 1160 Forsman

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RAYMOND	WALTER	RODGERS	Oct. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	married	Sept. 21, 1912	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
bartender 23		Southwick, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Russell Rodgers	Neb.	Martha Bleck	Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-05-2590	X Mabel Rodgers	Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE MYOCARD. INFARCT — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) CORONARY THROMBOSIS — 1 Day

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* OCT 24, 1969, *to* OCT 24, 1969, *that I last saw the deceased alive on* OCT 24, 1969, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
013 MD	307 Jt Idaho Lewiston	10/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town or county) (State)
burial	Oct. 27, 69	Sunnyside	Lenore, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 31, 1969	Vern M Burger		476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4856
Local Reg. No. 274
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: NezPerce 351 — NOV 4 1969 (Bureau of Vital Statistics)
b. CITY OR TOWN: Lewiston — LENGTH OF STAY: 9days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston, (Hatwai)
d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print): a. (First) Beatrice — b. (Middle) O. — c. (Last) Gunter

4. DATE OF DEATH: (Month) (Day) (Year) Oct 25, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 18, 1900

9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music teacher 12

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Harpster, Idaho.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Farris — BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Pruda Mason — BIRTHPLACE: Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY: 518-22-5241 NO A

17. INFORMANT'S OWN SIGNATURE: — ADDRESS: Lewiston, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4276

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Organic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cancer in Abdomen

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-16-, 1969, *to* 10-25-, 1969, *that I last saw the deceased alive on* 10-24-1969, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Allen M Cochrane MD — **23b. ADDRESS**: — **23c. DATE SIGNED**: 10-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3 — **24b. DATE**: Oct 27, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Prairie View Cemetery — **24d. LOCATION** (City, town, or county) (State): Grangeville, Idaho.

DATE REC'D BY LOCAL REG.: 10-27-69 — **REGISTRAR'S SIGNATURE**: Glenn Walzer — **25. EMBALMER**: Andrew H. Vassar — **LICENSE NO.**: E 315

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

NOV 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4857
Local Reg. No. 283
Reg. Dist. No. 220

RECEIVED NOV 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 357
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 1 yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor Nursing Home 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 352
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lenore
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ARTHUR	LAWSON	ANDERSON	26 October 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	27 Nov. 1891	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Stock & Grain	Laurel, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John F. Anderson	Iowa	Rachel Robinson	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519 03 6920	Madge Anderson	Lenore, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) mycardial infarct. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-24-69, *19*, *to* 10-26-, *19* 69, *that I last saw the deceased alive on* 10-26-69, *19*, *and that death occurred at* 12:48 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X [signature] 502 MD	Lewiston, Idaho	10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	28 Oct 1969	Lewis-Clark Memo. Gard.	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-10-69	Leonard Dalgren	W E Black	E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4858
Local Reg. No. 275
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 357
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPHS HOSPIYAL 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: WASHINGYON 48
b. COUNTY: ASOTIN 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ASOTIN
d. STREET ADDRESS (If rural, give location): CITY

3. NAME OF DECEASED (Type or Print)
a. (First): ANNIE
b. (Middle): (NMI)
c. (Last): BLANKENSHIP

4. DATE OF DEATH (Month) 10 (Day) 27 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 8, 1889
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Pomeroy, Wash.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lewis Blankenship — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Johanna ---- — BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 534-28-3780
17. INFORMANT'S OWN SIGNATURE: E. R. Blankenship — ADDRESS: Asotin, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1631

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 3, 1967, *to* Oct. 27, 1969, *that I last saw the deceased alive on* Oct. 27, 1969, *and that death occurred at* 9:35 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] Bob Baldwin
23b. ADDRESS: 625 6th Ave., Lewiston
23c. DATE SIGNED: 10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct. 30, 1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 10-28-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: [signature] Merchant
LICENSE NO.: FD 5

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Merchant Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 5 1969

JAN 14 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4859
Local Reg. No. 284
Reg. Dist. No. 220

Certificate of Death

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 357
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 5 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1707 - 7th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): ELLA
b. (Middle): VIOLA
c. (Last): STANTORF

4. DATE OF DEATH (Month) (Day) (Year): 27 October 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 19 Aug 1871
9. AGE (In years last birthday): 98 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Reuben Dutcher — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Lucy ? — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no record
17. INFORMANT'S OWN SIGNATURE: S. J. Cook — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Infirmities of age

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on* 10/27/, 1969, *and that death occurred at* 10:50AM, *from the causes and on the date stated above.*

23a. SIGNATURE: John E. Cassmore 083 (Degree or title)
23b. ADDRESS: 9th & Main Lewiston Idaho
23c. DATE SIGNED: 10/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 30 Oct 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-10-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Patient of G. A. Rogers, M.D.
out of town at time of death

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4860
Local Reg. No. 280
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nezperce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nelson Nursing Home 129

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Craigmont
d. STREET ADDRESS (If rural, give location) Craigmont

3. NAME OF DECEASED (Type or Print)
a. (First) DELCIA
b. (Middle) ANN
c. (Last) STINWALT

4. DATE OF DEATH (Month) (Day) (Year) Oct 27, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan 6, 1878

9. AGE (In years last birthday) 91
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Colorado Springs, Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Sense
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Sarah Capps
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Yes

17. INFORMANT'S OWN SIGNATURE ADDRESS Lewiston, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Infirmities of age
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-15, 1969, *to* 10/27, 1969, *that I last saw the deceased alive on* 9-15, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE R. M. Stover (Degree or title) M D

23b. ADDRESS 939 Bryden Lewiston, Idaho

23c. DATE SIGNED 11/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/31/1969

24c. NAME OF CEMETERY OR CREMATORY Prairieview

24d. LOCATION (City, town, or county) Grangeville, Idaho (State)

DATE REC'D BY LOCAL REG. 11-7-69

REGISTRAR'S SIGNATURE R. M. Stover MD

25. EMBALMER Cletus Uhlorn

LICENSE NO. E 421

FIRM NAME: Hanson Funeral home

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4861
Local Reg. No. 2791
Reg. Dist. No. 220

BIRTH NO.

RECEIVED NOV 10 1969 Vital Statistics Bureau

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 904 - 7th Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HARRY	WEBSTER	CHRISTY	28 October 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	3 August 1890	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Agency Owner 22	Insurance	Arkansas City, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Christy	Davis Co., Iowa	Elva Fiedler	Davis Co., Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW-I 3	519 09 3032	Nora A. Christy	Lewiston, Id.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Failure, Congestive — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Asthenia, due to Infarction — "

DUE TO (c) Heart Block - Senile Arteriosclerosis — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Prostatic pre-malignancy since 1963

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug, 1969, *to* Oct 28, 1969, *that I last saw the deceased alive on* Oct 28, 1969, *and that death occurred at* 5:30 PM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orion M. Brewer MD	247 Elm, Lewiston, Ida.	11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	31 Oct 1969	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-4-69	Glenara Dalzell	L. E. DeBaun	E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DUTIES:

NOV 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 16 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

BIRTH NOV 4 1969

Certificate of Death

STATE OF IDAHO

State File No. 4862
Local Reg. No. 328
Reg. Dist. No. 220

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY NezPerce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Mannor 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) Jess Apt.

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) R. c. (Last) Call

4. DATE OF DEATH (Month) (Day) (Year) Oct 29 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 3, 1880

9. AGE (In years last birthday) 88 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Lewiston, Idaho.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Eugene A. Rowley BIRTHPLACE Peoria, Ill.

14. MOTHER'S MAIDEN NAME Ella Taylor Hanna BIRTHPLACE Dayton, Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-12-4254

17. INFORMANT'S OWN SIGNATURE Emma Call ADDRESS Lewiston, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

401K

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension

INTERVAL BETWEEN ONSET AND DEATH Years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 1969, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Allen M. Cochrane MD

23b. ADDRESS Lewiston

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE Oct 31, 1969

24c. NAME OF CEMETERY OR CREMATORY Ball & Dodd

24d. LOCATION (City, town, or county) (State) Spokane, Wash.

DATE REC'D BY LOCAL REG. 10-30-69

REGISTRAR'S SIGNATURE Glenna Wolgen

25. EMBALMER V. Vassar

LICENSE NO. E 297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4863
Local Reg. No. 70
Reg. Dist. No. 530

BIRTH NO.

RECEIVED STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Oneida 360

OCT 15 1969

Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City

c. LENGTH OF STAY (in this place): 1 week

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oneida County Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Oneida 360

c. CITY OR TOWN (If outside corporate limits, write RURAL and give street address): 29 East 100 North

Spouse: Helen Davis

d. STREET ADDRESS (If rural, give location): Malad City, Idaho 83252

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	SIDNEY	JAMES	FOLLAND	OCT. 9 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married	Nov. 15, 1892	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic, auto salesman

10b. KIND OF BUSINESS OR INDUSTRY: Garage & Motor

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY FOLLAND — BIRTHPLACE: Salt Lake City, Ut.

14. MOTHER'S MAIDEN NAME: MARTHA URIE — BIRTHPLACE: Beaver, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WORLD WAR I 3

16. SOCIAL SECURITY NO.: 519-36-5129

17. INFORMANT'S OWN SIGNATURE: x Helen Folland — ADDRESS: Malad, Ida.

4189

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 2, 1969, *to* Oct. 9, 1969, *that I last saw the deceased alive on* Oct. 9, 1969, *and that death occurred at* 10:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John A Jones 899	M.D.	Malad City, Idaho	Oct. 11, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 13, 1969	Malad City Cemetery	Malad, Oneida, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 11, 1969	Ruth B. Sweeten	Raiford G. Benson	E-351

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

DUTIES:

OCT 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 30 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4864
Local Reg. No. 38
Reg. Dist. No. 530

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Oneida 36 NOV 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Near Stone, Idaho
c. LENGTH OF STAY (in this place) hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) none, near Stone 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Utah 45
b. COUNTY Cache 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Providence
d. STREET ADDRESS (If rural, give location) Providence

3. NAME OF DECEASED (Type or Print) a. (First) HERMAN b. (Middle) NEAL c. (Last) COTTAM

4. DATE OF DEATH (Month) (Day) (Year) OCT, 22, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 2-1911
9. AGE (In years last birthday) 58 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 27 Trucker and Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Stone, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Cottam BIRTHPLACE Unk.
14. MOTHER'S MAIDEN NAME Harriett Neal BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ?/
17. INFORMANT'S OWN SIGNATURE Georgia Cottam ADDRESS Providence, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH 15 MIN

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 4:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Myron Fullmer 588 5 ONEIDA CO. SPEC. DEP. SHERIFF (Degree or title)
23b. ADDRESS MALAD, IDAHO
23c. DATE SIGNED 24 OCT 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem/Burial 3
24b. DATE Oct. 25, 1969
24c. NAME OF CEMETERY OR CREMATORY Logan C m.
24d. LOCATION (City, town, or county) (State) Logan, Utah

DATE REC'D BY LOCAL REG. Oct. 29-1969
REGISTRAR'S SIGNATURE Ruth G. Sweeten
25. EMBALMER W. Loyal Hall LICENSE NO. E-268

FIRM NAME: HALL MORTUARY: LOGAN, UTAH

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

Ruth Sweeten
Registrar

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4865
Local Reg. No. 21
Reg. Dist. No. 530

BIRTH NO.

RECEIVED NOV 10 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Oneida 360
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad
LENGTH OF STAY (in this place): 80 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oneida Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Oneida 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad
d. STREET ADDRESS (If rural, give location): 735 North 400 West St.

3. NAME OF DECEASED (Type or Print): a. (First) SARAH b. (Middle) JANE c. (Last) K.(initial) EVANS

4. DATE OF DEATH: (Month) October (Day) 30, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: June 12, 1889

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Telephone operator 59

10b. KIND OF BUSINESS OR INDUSTRY: *Mtn. States Tel. & Tel.

11. BIRTHPLACE (State or foreign country): Malad, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Richards Evans — BIRTHPLACE: St. Joseph, Missouri

14. MOTHER'S MAIDEN NAME: Ann Elizabeth Colton Kniveton — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-07-2491A

17. INFORMANT'S OWN SIGNATURE: Charlotte K. Evans — ADDRESS: Malad, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1547

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic vasc. disease

DUE TO (c) Metastatic carcinoma (rectal)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* to periaostic & mesenteric nodes

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 27 Oct, 1969, *to* 30 Oct, 1969, *that I last saw the deceased alive on* 29 Oct, 1969, *and that death occurred at* 7:40A m., *from the causes and on the date stated above.*

23a. SIGNATURE: John A. Jones 899 — (Degree or title) M.D.

23b. ADDRESS: Malad, Idaho

23c. DATE SIGNED: 11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 3, 1969

24c. NAME OF CEMETERY OR CREMATORY: St. John Cemetery

24d. LOCATION (City, town, or county) (State): Oneida County, Idaho

DATE REC'D BY LOCAL REG.: Nov 3-1969

REGISTRAR'S SIGNATURE: Ruth G. Sweeten

25. EMBALMER: Ford G. Benson

LICENSE NO.: E-351

FIRM NAME: BENSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 1 0 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4866
Local Reg. No. 62
Reg. Dist. No. 380-391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 37 Owyhee — OCT 15 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grasmere, ID
c. LENGTH OF STAY (in this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 67 Tac Hosp, Mtn Home AFB, ID

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Home AFB, Idaho
d. STREET ADDRESS (If rural, give location) 10 TRS- BOQ

3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) (NMI) c. (Last) Biolley
4. DATE OF DEATH (Month) Oct (Day) 2 (Year) 1969
5. SEX Male
6. COLOR OR RACE CAU
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 5 Jun 1928
9. AGE (In years last birthday) 41 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Senior Pilot 05
10b. KIND OF BUSINESS OR INDUSTRY USAF
11. BIRTHPLACE (State or foreign country) Los Angeles, California
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Gonzalo Biolley- Switzerland
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Adel - Robeles
BIRTHPLACE Hermosa, Mexico
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 18Sep50-20Oct69
16. SOCIAL SECURITY NO. 547-30-7943
17. INFORMANT'S OWN SIGNATURE Official Medical Records
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of Heart — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aircraft Accident

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 8 miles West 16
21c. (CITY, TOWN, OR TOWNSHIP) Grasmere 13370 (COUNTY) Owyhee (STATE) Idaho
21d. TIME OF INJURY (Month) Oct (Day) 2 (Year) 1969 (Hour) 2315 p m.
21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? Aircraft accident

22. *I hereby certify that I attended the deceased from* Oct 3, 1969, *to* Oct 3, 1969, *that I last saw the deceased alive on* NEVER, 19____, *and that death occurred at* 2315 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward T. Kimble (Degree or title) M.D.
23b. ADDRESS Mtn Home AFB, Idaho
23c. DATE SIGNED

24a. DISPOSITION (Burial, Cremation, Removal) (Specify) BURIAL
24b. DATE 10-6-69
24c. NAME OF CEMETERY OR CREMATORY SANTA BARBARA, CALIF
24d. LOCATION (City, town, or county) (State) SANTA BARBARA CALIF.

DATE REC'D BY LOCAL REG. Oct 9 1969
REGISTRAR'S SIGNATURE
25. EMBALMER Arthur Smith
LICENSE NO. E-403
FIRM NAME: SMITH MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 19 1982

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 11 1998

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
UCT 1 5 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4867
Local Reg. No. 61
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grasmere, ID
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 67 Tac Hosp, Mtn Home AFB, ID 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn Home AFB, Idaho
d. STREET ADDRESS (If rural, give location): 4210F Mtn Village

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JAMES	EDWARD	COLEMAN	Oct	2	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	CAU	Married	26 Nov 1944	24				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Navigator 05
10b. KIND OF BUSINESS OR INDUSTRY: USAF
11. BIRTHPLACE (State or foreign country): Columbus, Georgia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Monroe Coleman-Tallassee, Ala
14. MOTHER'S MAIDEN NAME: Lillian Ophelia Chandler
BIRTHPLACE: Autuga, County Alabama
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes 18 Jul 62-20 Oct 69
16. SOCIAL SECURITY NO.: 265-74-7997
17. INFORMANT'S OWN SIGNATURE: Official Medical Records
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of Heart

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Blunt Trauma
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 8 miles West 16
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Grasmere 13370 Owyhee Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 2 1969 2315 p.m.
21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? Aircraft accident

22. *I hereby certify that I attended the deceased from* Oct 3, 19 69, *to* Oct 3, 19 69, *that I last saw the deceased alive on* NEVER, 19 , *and that death occurred at* 2315 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edward T. Kimble 585 M (Degree or title): M. D.
23b. ADDRESS: Mtn Home AFB, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 10-6-69
24c. NAME OF CEMETERY OR CREMATORY: COLORADO SPRINGS, COLO.
24d. LOCATION (City, town, or county) (State): COLORADO SPRINGS, COLO.

DATE REC'D BY LOCAL REG.: Oct 9 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E-502
FIRM NAME: SMITH MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4868
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

RECEIVED OCT 20 1969

1. PLACE OF DEATH
a. COUNTY Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale Burns
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Calif. 05
b. COUNTY Marin 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) San Rafael
d. STREET ADDRESS (If rural, give location) 108 Trellis Dr.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lewis		Staunch	Oct. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 24, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Air-Force 05	US Air Force	PLeasant City, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Stanch	Czechoslovakia	Mary Petras	Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WWII--Korea 6	277-16-5996	X Dana H. Staunch	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8129

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive head injury — INTERVAL BETWEEN ONSET AND DEATH: Instant.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Broken Neck
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 95 06	Marsing 13370 Owyhee Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21f. HOW DID INJURY OCCUR?
Oct. 9 1969 11:15 a.m.		Five Car & truck pile up due to dense smoke.

22. I hereby certify that I ~~attended the deceased from~~ did not attend- investigation only 19__, to __, that I ~~last saw the deceased alive~~ did not on Oct. 9, 1969, and that death occurred at 11:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Andrew Warfield 583 (Degree or title) Coroner	Homedale, Idaho	Oct. 12 '69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-11-69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 12 '69	Andrew Warfield	Leonard C. Blakiff	E-481

FIRM NAME: Homedale's Blakiff Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 4 1969
OCT 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4869
Local Reg. No. 392
Reg. Dist. No.

RECEIVED
Bureau of Vital Statistics
NOV 4 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and the township): Rural, Sheaville
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 Air Miles from Sheaville 602

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: Eldorado 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): So. Lake Tahoe
d. STREET ADDRESS (If rural, give location): P.O. Box 9729

3. NAME OF DECEASED (Type or Print)
a. (First): Evelyne
b. (Middle): B.
c. (Last): Miller

4. DATE OF DEATH (Month) (Day) (Year): Oct. 28, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 3-8-1919

9. AGE (In years last birthday): 50
IF UNDER 1 YEAR — Months: 7 Days: 20
IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): ElPaso, Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John G. DeHoney
BIRTHPLACE: Louiseville, Ky.

14. MOTHER'S MAIDEN NAME: Leona Baunghs
BIRTHPLACE: Pierey, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: Danielle Lee Stanshaw
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 8414 Massive Anatomical Mutilation — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Mountains 16.
21c. (CITY, TOWN, OR TOWNSHIP) 13370 **(COUNTY)** Rural Sheaville Owyhee **(STATE)** Ida.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-28-69 8:30 A.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: Airplane Crash - due to icing up -

22. *I hereby certify that I attended the deceased from did investigation, 19, to Oct. 29, 1969, that I last saw the deceased alive on Oct. 29, 1969, and that death occurred at 8:30 A.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Andrew Warfield MD Coroner
23b. ADDRESS: Homedale, Idaho
23c. DATE SIGNED: 10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 11-3-1969
24c. NAME OF CEMETERY OR CREMATORY: Inglewood Park Cemetery
24d. LOCATION (City, town, or county) (State): Inglewood, Calif.

DATE REC'D BY LOCAL REG.: 10-31-69
REGISTRAR'S SIGNATURE: Andrew Warfield
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Homedale's Flahiff Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 0 4 2008

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4870
Local Reg. No. 392
Reg. Dist. No.

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Sheaville
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 Air Miles from Sheaville 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: Los Angeles 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hawthorne
d. STREET ADDRESS (If rural, give location): 13922 Chadron Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Lawrence
b. (Middle): Byron
c. (Last): Miller

4. DATE OF DEATH (Month) (Day) (Year): Oct. 28, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3-6-1942
9. AGE (In years last birthday): 27 — IF UNDER 1 YEAR: Months 7, Days 22 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber 21
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Los Angeles, Calif.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Kenneth J. Miller — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Evelyn B. DeHoney — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 555-56-73 48 Unknown
17. INFORMANT'S OWN SIGNATURE: Harriette Lee Stanshaw — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8414

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Anatomical Mutilation — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Mountains 16
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rural Sheaville 13 370 Owyhee Ida.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-28-69 8:30 A.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: Airplane Crash - due to icing up -

22. *I hereby certify that I ~~attended~~ did investigation ~~the deceased from~~ ~~10~~ ~~to~~ Oct. 29, 1969, that I ~~last saw the~~ did not see deceased alive on Oct. 29, 1969, and that death occurred at 8:30 A.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Andrew Warfield 583 4 - Coroner
23b. ADDRESS: Homedale Idaho
23c. DATE SIGNED: 10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10-31-1969
24c. NAME OF CEMETERY OR CREMATORY: Inglewood Park Cemetery, Inglewood, Calif.
24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: 10-31-69
REGISTRAR'S SIGNATURE: Andrew Warfield
25. EMBALMER: Leonard C. Flahiff — LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Homedale's Flahiff Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4871
Local Reg. No. 592
Reg. Dist. No.

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
NOV 4 1969

1. PLACE OF DEATH
a. COUNTY Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Sheaville
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5 Air Miles from Sheaville 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Calif 05
b. COUNTY Los Angeles 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hawthorn
d. STREET ADDRESS (If rural, give location) 3204 W. 139th St.

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Raymond c. (Last) Syfers

4. DATE OF DEATH (Month) (Day) (Year) Oct. 28, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 10-23-1944

9. AGE (In years last birthday) 25 — IF UNDER 1 YEAR: Months 0, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Passage Agent 10

10b. KIND OF BUSINESS OR INDUSTRY United Airlines

11. BIRTHPLACE (State or foreign country) Long Beach, Calif.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William R. Syfers, Sr. — BIRTHPLACE Ohio

14. MOTHER'S MAIDEN NAME Betty Fosdick — BIRTHPLACE Florida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 573-60-1306

17. INFORMANT'S OWN SIGNATURE Del Fox of Pierce Brothers Funeral Home, Lawndale, Calif. — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8414

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Anatomical Mutilation — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10-30-69

19b. MAJOR FINDINGS OF OPERATION Negative

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Mountain Canyon

21c. (CITY, TOWN, OR TOWNSHIP) Rural Sheaville 13370 **(COUNTY)** Owyhee **(STATE)** Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10 - 28 - 69 8:30 A m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY Ooccur? Airplane Crash - due to icing up -

22. *I hereby certify that I attended the deceased from did investigation only, 19—, to Oct. 29, 1969, that I last saw the deceased alive on Oct. 29, 1969, and that death occurred at 8:30 A m., from the causes and on the date stated above.*

23a. SIGNATURE Andrew Kanfield (Degree or title) 583 - Coroner

23b. ADDRESS Homedale, Idaho

23c. DATE SIGNED 10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 10-31-1969

24c. NAME OF CEMETERY OR CREMATORY Pacific Crest Cemetery

24d. LOCATION (City, town, or county) (State) Redondo, Beach, Calif.

DATE REC'D BY LOCAL REG. 10-31-69

REGISTRAR'S SIGNATURE Andrew Kanfield

25. EMBALMER Leonard C. Flaniff

LICENSE NO. E-481

FIRM NAME: Homedale's Flaniff Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4872
Local Reg. No. 145
Reg. Dist. No. 330

RECEIVED OCT 9 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 30 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 13 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt 1 Box 26

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) Rt 1 Box 26

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Severt	Francis	Dolphus	Oct	3	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Indian	Married	March 26 1914	55				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Equipment Operator	Construction	South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John William Dolphus	Unknown	Emma Pearman	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War II	503-18-7579	Lee Thompson By Donald F Brown	Payette, Ida

1621

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Carcinoma with

ANTECEDENT CAUSES extensive metastases

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 1 year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 68, 19___, *to* Oct 3, 69 19___, *that I last saw the deceased alive on* 9-18-69 19___, *and that death occurred at* 3:40a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] MD	Payette, Idaho	10-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-6-69	Rosedale Memorial Grds.	Payette, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-7-69	[signature]	Donald F Brown	E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 10 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4873
Local Reg. No. 747
Reg. Dist. No. 330

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 1019 3 Ave. S

3. NAME OF DECEASED (Type or Print)
a. (First) Nannie
b. (Middle) Lee
c. (Last) Langevin

4. DATE OF DEATH (Month) Oct (Day) 7 (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 27, 1892

9. AGE (In years last birthday) 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Homemaking

11. BIRTHPLACE (State or foreign country) Hill City, South Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Remington
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 544-58-3995

17. INFORMANT'S OWN SIGNATURE Evelyn Frith 963 S. W 4th St ADDRESS Ontario

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Abdominal aortic aneurysm.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic cardiovascular disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Lewis Evans MD

23b. ADDRESS 915 S.W. 3rd Ave, Ontario, Ore.

23c. DATE SIGNED 10-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 10, 1969

24c. NAME OF CEMETERY OR CREMATORY Rosedale Memorial Gdns

24d. LOCATION (City, town, or county) (State) Payette, Payette, Idaho

DATE REC'D BY LOCAL REG. 10-9-69

REGISTRAR'S SIGNATURE Annabel Anderson

25. EMBALMER Milford O Driggs

LICENSE NO. E318

FIRM NAME: Chapel of The Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 11 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JAN 9 1986

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4874
Local Reg. No. 148
Reg. Dist. No. 330

BIRTH NO.

RECEIVED OCT 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 2 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 345 N 5th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elizabeth	W.	HARLAND	October 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	November 24, 1894	74	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Norton, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Morris Walker Watts	Iowa	Annie Renner	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— —	518-07-7929A	Charles E. Harland	Ontario, Ore.

MEDICAL CERTIFICATION

4189

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aoute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Convalescent stroke with hemiplegia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1960, *to* Octover, 1969, *that I last saw the deceased alive on* 10/4/69, 19—, *and that death occurred at* 7:45A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas W. Watts Jr M.D.	Payette, Idaho	10/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 14, 1969	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-17-69	[signature]	Keith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 1 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4875
Local Reg. No. 149
Reg. Dist. No. 330

RECEIVED
Bureau of Vital Statistics
OCT 22 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
LENGTH OF STAY (in this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. #1, North 9th St. Ext. 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) Route #1 North 9th St. Extension

3. NAME OF DECEASED (Type or Print) a. (First) SHARILYN b. (Middle) MARIE c. (Last) PATRICK
4. DATE OF DEATH (Month) (Day) (Year) October 15, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH December 13, 1941
9. AGE (In years last birthday) 27 IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Laborer
10b. KIND OF BUSINESS OR INDUSTRY Fruit Packing
11. BIRTHPLACE (State or foreign country) Payette, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Claude L. Patrick
BIRTHPLACE Nebraska
14. MOTHER'S MAIDEN NAME Roberta C. Otto
BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-50-7807
17. INFORMANT'S OWN SIGNATURE Claude L. Patrick ADDRESS Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congenital narrowing coronary arteries
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Repaired intraventric septal defect with other anomanlies.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/2/1962, *to* 10/15/69, 19___, *that I last saw the deceased alive on* 9/29, 19 69, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Thomas W. Watts Jr (Degree or title) M.D.
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 10/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 18, 1969
24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery
24d. LOCATION (City, town, or county) Payette (State) Idaho

DATE REC'D BY LOCAL REG. 10-21-69
REGISTRAR'S SIGNATURE Carmabel Anderson
25. EMBALMER Keith M. Jensen
LICENSE NO. E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4876
Local Reg. No. 150
Reg. Dist. No. 330

RECEIVED
Bureau of Vital Statistics
OCT 31 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN Payette
LENGTH OF STAY (in this place) Few Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route #1-1 Mi. So. of City

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California
b. COUNTY Santa Cruz 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Watsonville
d. STREET ADDRESS (If rural, give location) 13 Longview Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Peter	Blas	LETTUNICH	October 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	March 13, 1911	58	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant & Farmer 22
10b. KIND OF BUSINESS OR INDUSTRY: Tavern and Farming
11. BIRTHPLACE (State or foreign country): Yugoslavia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Lettunich	Yugoslavia	Katherine Prokuriza	Yugoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - -
16. SOCIAL SECURITY NO. 558-48-7634
17. INFORMANT'S OWN SIGNATURE Michael P. Lettunich ADDRESS Payette, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: SECONDS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CORONARY ARTERIOSCLEROSIS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. D.O.A. AT LOCAL HOSPITAL

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* MAY, 1969, *to* MAY, 1969, *that I last saw the deceased alive on* MAY, 1969, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jam[illegible] 684	M.D.	Ontario, Oregon	10-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	10-25-1969	Watsonville	Watsonville California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-30-69	[signature]	[signature]	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 3 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 1 2 2000 APR 2 7 1999

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 1 1 2000

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4877
Local Reg. No. 15
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: POWER 390
OCT 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Shiller RR Crossing
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 11.4 Mi. East Am. Falls

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 3844 Jason

3. NAME OF DECEASED (Type or Print): a. (First) JIM; b. (Middle); c. (Last) CONWAY

4. DATE OF DEATH: (Month) Oct. (Day) 11, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 12, 1931

9. AGE (In years last birthday): 38
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Spain

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Korean Con. 6

16. SOCIAL SECURITY NO.: 345253823

17. INFORMANT'S OWN SIGNATURE: Mary Conway ADDRESS: Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
8100

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Skull fracture — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Train-Truck collision
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Multiple fractures, arms, legs, Torso

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): RR Crossing 10
21c. (CITY, TOWN, OR TOWNSHIP) 13390 (COUNTY) (STATE): 11.4 miles East Am. Falls, Power, Idaho

21d. TIME OF INJURY (Month) Oct. (Day) 11, 1969 (Year) (Hour) 3:30 p.m.
21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? Train-truck collision

22. *I hereby certify that I attended the deceased from* XXXX

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4878
Local Reg. No. 76
Reg. Dist. No. 500-602

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390
b. CITY OR TOWN American Falls
c. LENGTH OF STAY (in this place) 2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location) 724 Hutchinson

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	AMANDA	MATHILDA	MEADOWS	Oct. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Widowed	March 30, 1873	96	6	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife of	Home	Coalville, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Garn	Fremont, Ohio	Esther A. Eldridge	Indianapolis, Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-54-0893	Ward W. Meadows	Am. Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Massive Pulmonary Embolism	10 min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	18 yrs.
DUE TO (c)	Chronic cholecystitis and	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	cholelithiasis	25 yrs.
	Arteriosclerosis	18 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January, 1963, *to* October 24, 69 *that I last saw the deceased alive on* 10-24, 1969, *and that death occurred at* 1:02p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. L. Harris 203 M.D.	American Falls, Idaho 213 Idaho Street	10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-28-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
October 31, 1969	Irene Deeg	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 30 1974

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4879
Local Reg. No. 17
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: POWER 390 NOV 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place): 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: POWER 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location): 649 Tyhee Ave.

3. NAME OF DECEASED (Type or Print): a. (First) EMIL b. (Middle) HENRY c. (Last) ROTH

4. DATE OF DEATH: (Month) Oct. (Day) 25, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 15, 1906

9. AGE (In years last birthday): 63 IF UNDER 1 YEAR Months: 8 Days: 10 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dispatcher

10b. KIND OF BUSINESS OR INDUSTRY: to San. Fran. Trans. Co.

11. BIRTHPLACE (State or foreign country): Berlin, RUssia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry G. Roth BIRTHPLACE: Odessa, Russia

14. MOTHER'S MAIDEN NAME: Christina Roth BIRTHPLACE: Odessa, Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 560-05-5477

17. INFORMANT'S OWN SIGNATURE: x Jasobin Roth ADDRESS: Am. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-21, 1969, *to* 10-25, 1969, *that I last saw the deceased alive on* 10-25, 1969, *and that death occurred at* 8:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] D **23b. ADDRESS**: American Falls, Idaho **23c. DATE SIGNED**: 10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial **24b. DATE**: 10-29-69 **24c. NAME OF CEMETERY OR CREMATORY**: Fallsview Cemetery **24d. LOCATION** (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: October 31, 1969 **REGISTRAR'S SIGNATURE**: Irene Deeg

25. EMBALMER: H. L. Davis LICENSE NO.: E-253
FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: NOV 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 10 1969 Bureau of Vital Statistics

State File No. 4880
Local Reg. No. 18
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 340 Power
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural (Shiller RR Crossing
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 11.4 mi. East Am. Falls 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 192 Berryman Road

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DONALD	GENE	BARNEY	Oct. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	June 28, 1947	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truckdriver 27	Bannock Paving	Amarillo, Texas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ivan Barney		Bonnie Jean Wells	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX	519 52 2319	[signature]	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8100

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed chest, Basal Skull fracture

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Train-car collision
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 3390 (COUNTY) (STATE)
Accident	RR Crossing 10	11.4 miles east Am. Falls, Power, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Oct. 29, 1969 8:02p. m.		Train-car collision

22. *I hereby certify that I attended the deceased from* XXXX

NOV 13 1969

DEC 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

OCT 14 1969

BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 4881

Local Reg. No. 171

Reg. Dist. No. 140

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY IN THIS PLACE D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hosp. 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location) 707 4th

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Rodney	W.	Truesdell		10	4	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	9-19-1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butcher 21	Meat Cutting	Mace, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William F. Truesdell	Omaha, Nebraska	Grace Mertsky	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-01-6718	X Hannah Truesdell	Mullan, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-4-, 1969, *to* 10-4, 1969, *that I last saw the deceased alive on* 10-4, 1969, *and that death occurred at about* 5:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE T. M. Peterson, M.D. (Degree or title) — 23b. ADDRESS Wallace, Idaho — 23c. DATE SIGNED 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	10-7-1969	Smith Funeral Home	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-9-69	Joe Irvine	Alan H Peterson	E 534

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4882
Local Reg. No. 23
Reg. Dist. No. 1-42

BIRTH NO.

RECEIVED OCT 20 1969

1. PLACE OF DEATH
a. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg R.
c. LENGTH OF STAY (in this place) 52 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 410 S. Division ooo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 410 S. Division

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CLARENCE	W.	FERGUSON	10	5	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	June 11, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	La Grande, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Ferguson	England	Henrietta Charles	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	518-03-4690	Mrs Margaret Ferguson	Kellogg, Ida.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-5 1969, *to* 10-5, 1969, *that I last saw the deceased alive on* 10-5, 1969, *and that death occurred at* about 6:15 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. M. Peterson, M.D. 419	Wallace, Idaho	10-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 9, 1969	Greenwood Cemetery	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-69		Ronald D. Nikel	E-520

FIRM NAME: Cornell's Maisel Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4883
Local Reg. No. 74
Reg. Dist. No. 142

BIRTH NO.

RECEIVED
OCT 15 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Shoshone 40
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
LENGTH OF STAY (In this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Smelterville
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) HAZEL b. (Middle) GRACE c. (Last) McMONAGLE

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Jan. 26

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Layton, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William J. Barton
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Euphemia Meredith
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 536-03-9905

17. INFORMANT'S OWN SIGNATURE: X Marjorie Liepold
ADDRESS: Smelterville Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 5-10 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes mellitus
Terminal bronchopneumonia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6, 1965 *to* Oct 7, 1969, *that I last saw the deceased alive on* Oct 7, 1969 *and that death occurred at* 8:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Orland B Brown MD

23b. ADDRESS: Kellogg Idaho

23c. DATE SIGNED: Oct 10 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: Oct. 11, 1969

24c. NAME OF CEMETERY OR CREMATORY: Smith & Company

24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 10-13-69

REGISTRAR'S SIGNATURE

25. EMBALMER: Russell D. Maisel

LICENSE NO.: E-520

FIRM NAME: Cornell's Maisel Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4884
Local Reg. No. 76
Reg. Dist. No. 142

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 27 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Enaville
c. LENGTH OF STAY (in this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little N. F. River, Owl C. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst
d. STREET ADDRESS (If rural, give location): Pine Creek

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Bradley
c. (Last): Sammons

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 26, 1921
9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic Helper 07
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dewey Sammons — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Florence Adams — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 407-22-3154
17. INFORMANT'S OWN SIGNATURE: x Irene Sammons — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

916X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Comminuted Fractures of Skull — INTERVAL BETWEEN ONSET AND DEATH: 1 second

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Rural Enaville 12
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rural Enaville Shoshone 13400 Idaho
21d. TIME OF INJURY (Month) (Day) (Year): 10-7-69 about 3:40 P.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Hit by falling tree

22. *I hereby certify that I attended the deceased from* 10-7, 1969, *to* 10-7, 1969, *that I last saw the deceased alive on* 10-7, 1969, *and that death occurred at* about 3:40 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. M. Peterson, M.D. 414
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 10-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/11/1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Mem. Gardens
24d. LOCATION (City, town, or county) (State): Pinehurst, Idaho

DATE REC'D BY LOCAL REG.: 10-15-69
REGISTRAR'S SIGNATURE: Joe Irvine
25. EMBALMER: Dean H. Petersen
LICENSE NO.: E-534

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Maisel Fun'l Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 2 8 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In ~~case a person~~ has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4885
Local Reg. No. 75
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Shoshone 401 — OCT 27 1969 — Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg — c. LENGTH OF STAY (In this place): D.O.A.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho — b. COUNTY: Kootenai 281

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene

d. STREET ADDRESS (If rural, give location): 602 Reed

3. NAME OF DECEASED (Type or Print): a. (First) WAYNE — b. (Middle) HOWARD — c. (Last) OYLER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 8, 1969

5. SEX: male — 6. COLOR OR RACE: white — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married — 8. DATE OF BIRTH: July 7, 1921 — 9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator-Engineer 21 — 10b. KIND OF BUSINESS OR INDUSTRY: Heavy equip.

11. BIRTHPLACE (State or foreign country): Garfield, Washington — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: M. Oyler — BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Blanche Huggins — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War 24 — 16. SOCIAL SECURITY NO. 518-14-0156

17. INFORMANT'S OWN SIGNATURE: X Mary Oyler — ADDRESS: Coeur d'Alene, Ida.

8199

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Comminuted fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Fractured neck

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident — 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 10 06 near Kingston — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Shoshone 13400, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-8-69 about 7:28 P. m. — 21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒ — 21f. HOW DID INJURY OCCUR? Automobile accident

22. *I hereby certify that I attended the deceased from* 10-8, 1969, *to* 10-8-, 1969, *that I last saw the deceased alive on* 10-8, 1969, *and that death occurred at* about 7:28 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: T. M. Peterson, M.D. (Degree or title) — 23b. ADDRESS: Wallace, Idaho — 23c. DATE SIGNED: 10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3 — 24b. DATE: Oct. 11, 1969 — 24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery — 24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: 10-15-69 — REGISTRAR'S SIGNATURE: Joe Gavine — 25. EMBALMER: Dean D. Petersen — LICENSE NO. E-534

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Maisel Chapel

OCT 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 2 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 7 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4886
Local Reg. No. 66
Reg. Dist. No. 142

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 160 — OCT 27 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton — LENGTH OF STAY (in this place) 4 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone Co. Nursing Ho. (3X)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Shoshone 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cataldo
d. STREET ADDRESS (If rural, give location) 1 Mile East Hiway # 10

3. NAME OF DECEASED (Type or Print): a. (First) Anna — b. (Middle) Edla — c. (Last) Crawford

4. DATE OF DEATH (Month) (Day) (Year): Oct. 12, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 9, 1885

9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Axel Farger — BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO. 519-14-5292

17. INFORMANT'S OWN SIGNATURE: Lawrence Crawford — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Pancreas & metastases — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Hypertensive C.V.R. Disease — Seven years
Chronic Urinary Tract Infection — Seven years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-11, 1965, *to* 10-12, 1969, *that I last saw the deceased alive on* 10-12, 1969, *and that death occurred at* 6:05 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: T. M. Peterson (Degree or title) M.D. — 23b. ADDRESS: Wallace Idaho — 23c. DATE SIGNED: 10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 10/15/69 — 24c. NAME OF CEMETERY OR CREMATORY: Hunt's Cemetery — 24d. LOCATION (City, town, or county) (State): Kingston, Idaho

DATE REC'D BY LOCAL REG.: 10/22/69 — REGISTRAR'S SIGNATURE: Joe Keane — 25. EMBALMER: Russell D. Maisel — LICENSE NO.: E 520

FIRM NAME: Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4887
Local Reg. No. 78
Reg. Dist. No. 142

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 401
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 10dys.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osburn
d. STREET ADDRESS (If rural, give location): Mouth of 2 Mile Gulch

3. NAME OF DECEASED (Type or Print)
a. (First): Robert
b. (Middle): James
c. (Last): Mc Rae

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 11, 1908
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mining Engineer 07
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): Meadows, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dan Mc Rae — BIRTHPLACE: North Dakota
14. MOTHER'S MAIDEN NAME: Grace Turner — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-18-1030
17. INFORMANT'S OWN SIGNATURE: x Ruth C. McRae — ADDRESS:

18. CAUSE OF DEATH 5150
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Silicosis — INTERVAL BETWEEN ONSET AND DEATH: 25 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Emphysema — 25 yrs
R. Heart Decompensation — 10 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1964, 19__, *to* Oct 21, 1969, *that I last saw the deceased alive on* Oct 21, 1969, *and that death occurred at* 1:17 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 052 (Degree or title): J. E. Bourcoupe M.D.
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: Oct 22 - 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 10/25/1969
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10/29/69
REGISTRAR'S SIGNATURE: Joe Sabine
25. EMBALMER: Dean H. Petersen — LICENSE NO. E 534

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Maisel Fun'l Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 24 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4888
Local Reg. No. 173
Reg. Dist. No. 140

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
OCT 31 1969

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
b. CITY OR TOWN: Mullan
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Lucky Friday Mine 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN: Wallace
d. STREET ADDRESS (If rural, give location): Sweets Hotel

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Francis	Edward	Murinko	October 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	Oct. 20, 1929	40		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Rock Springs, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Michael Murinko	Unknown	Buelah Long	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	1947 to 1950 8	520-22-5826	Phillip L. Murinko	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Compound, Comminuted fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: One second

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractured Neck, Multiple
DUE TO (c) Crushing Wounds of Entire Body.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple abrasions of Entire Body

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	In Lucky Friday Mine	Mullan, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
10-21-69 4:50 P. m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Cave in - Blast

22. *I hereby certify that I attended the deceased from* 10-21, 1969, *to* 10-21, 1969, *that I last saw the deceased alive on* 10-21, 1969, *and that death occurred at* 4:50 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
T. M. Peterson	M.D.	Wallace, Idaho	10-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-25-69	Mullan Cemetery	Mullan, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-30-69	Hale Cornell	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 9 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 12 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

APR 29 1999

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-10664 RECEIVED NOV 6 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4889
Local Reg. No. 99
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN Silverton
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wardner
d. STREET ADDRESS (If rural, give location) 412 Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Michelle	Rae	LYONS	Oct. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	never married	Oct. 23, 1969				19	27

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
never employed 02	none	Silverton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Denton G. Lyons	Kellogg	Roswitha Alexander	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	none	Denton Lyons	Wardner, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7777

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity and Immaturity — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* birth, 19__, *to* 10/24, 69, *that I last saw the deceased alive on* 10/23/69, 19__, *and that death occurred at* 6:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Russell D. Mikel 435	MD	Wallace Idaho	10/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/27/1969	Greenwood Cemetery	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-30-69	Joe Devine	Russell D. Mikel	E-520

FIRM NAME Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4890
Local Reg. No. 80
Reg. Dist. No. 142

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 20 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): Kellogg

3. NAME OF DECEASED (Type or Print)
a. (First): Attlee
b. (Middle):
c. (Last): Mustoe

4. DATE OF DEATH (Month) (Day) (Year): October 31, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 7, 1890
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith 07
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Chambers Mustoe — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Elizabeth Hillyard — BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-05-1813A
17. INFORMANT'S OWN SIGNATURE: Walt Shaney — ADDRESS: Kellogg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Sclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Osteo-arthritis

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1969, *to* Oct 31, 1969, *that I last saw the deceased alive on* Oct 31, 1969, *and that death occurred at* 10:35 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. E. Bruebacher 052 M.D.
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: Nov 5, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/4/1969
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 11-12-69
REGISTRAR'S SIGNATURE: Joe Irvine
25. EMBALMER: Dean D. Peterson — LICENSE NO.: E 534

FIRM NAME: Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 23 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4891
Local Reg. No. 5
Reg. Dist. No. 620

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Driggs
c. LENGTH OF STAY (in this place) 2 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Teton County Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Victor
d. STREET ADDRESS (If rural, give location) none

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	Earl	Allen	Oct 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Jan 12, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Escalante, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isaac Thomas Allen	unknown	Martha Turner Allen	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-24-8049	Hanlon F. Allen	Victor, Ida

MEDICAL CERTIFICATION

493X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) COPD — 5 years
DUE TO (c) Bronchiolar asthma — all life

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1961, *to* Oct. 10, 1969, *that I last saw the deceased alive on* Oct. 10, 1969, *and that death occurred at* 10:45 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Driggs Idaho	10-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 13, 1969	Victor Cemetery	Victor, Teton Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-21-69	Ella Driggs	Robert Q. Bean	E-456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robert Bean Funeral Home

DUTIES:

JUN 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4892
Local Reg. No. 62
Reg. Dist. No. 620

BIRTH NO.

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (In this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
d. STREET ADDRESS (If rural, give location): 53 N 1 E

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elaine	Grace	Sewell	Oct 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Fem	White	Widowed	Mar 19, 1899	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	none	Providence, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Charles Gustaveson	Salt Lake, Utah	Amy S. Rammell	Providence, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-20-1586	Lois B. Stephenson	Rt 3 Rupert

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial Infarct	5 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	ASHD	<1 year
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

4109

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July, 1961, *to* Dec 1969, *that I last saw the deceased alive on* Oct 23, 1969, *and that death occurred at* 5:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Driggs Idaho	10-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 29, 1969	Driggs Cemetery	Driggs, Teton, Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-1-69	Ella Driggs	Robert Bean	E-456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robert Bean Funeral Home

DUTIES:

SEP 18 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4893
Local Reg. No. D-337
Reg. Dist. No. 460

BIRTH NO. OCT 8 1969

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420 (Bureau of Vital Statistics)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (In this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION: Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 1315 B Locust Street

3. NAME OF DECEASED (Type or Print): a. (First) ELNORA b. (Middle) E. c. (Last) DICKARD

4. DATE OF DEATH (Month) (Day) (Year): October 1, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: June 13, 1892

9. AGE (In years last birthday): 77
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beautician 21

10b. KIND OF BUSINESS OR INDUSTRY: Shop Owner

11. BIRTHPLACE (State or foreign country): Cedarville, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dan Shipman
BIRTHPLACE: Tennessee

14. MOTHER'S MAIDEN NAME: Juan Youngblood
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-36-2618 A

17. INFORMANT'S OWN SIGNATURE: Robert F. Dickard
ADDRESS: 200 9th Ave. N. Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart disease with Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: sev. years 1 mon.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Possible Cerebral Thrombosis about Aug 13, 1969
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe Malnutrition

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 10, 1967, to Oct 1, 1969, that I last saw the deceased alive on Sept 30, 1969, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE: Vern Henderson (Degree or title) M.D.

23b. ADDRESS: Buhl, Idaho

23c. DATE SIGNED: 10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/3/69

24c. NAME OF CEMETERY OR CREMATORY: Buhl

24d. LOCATION (City, town, or county): Buhl (State): Idaho

DATE REC'D BY LOCAL REG.: October 6, 1969

REGISTRAR'S SIGNATURE: Marna D. Marsh

25. EMBALMER: Ronald J. Hamilton

LICENSE NO.: E-470

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4894
Local Reg. No. D-325
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

421 OCT 7 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazeldel Manor Nursing H. 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer 83328
d. STREET ADDRESS (If rural, give location): Route # 2

3. NAME OF DECEASED (Type or Print)
a. (First): BERTHA
b. (Middle):
c. (Last): LANCASTER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 1, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept.12, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Edgar, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Voorhees — BIRTHPLACE: New Jersey
14. MOTHER'S MAIDEN NAME: Lucy Titus — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-44-0452
17. INFORMANT'S OWN SIGNATURE: X Mrs. Helen Penney — ADDRESS: Long Beach Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5719

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Partial Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 2years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) from Cirrhosis of Liver — Unknown
DUE TO (c) with bleeding Esaphageal Varices — 3 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/18, 1960, *to* 10/1, 1969, *that I last saw the deceased alive on* 10/1, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 578
23b. ADDRESS: 204 4th Ave. E. Twin Falls, Ida
23c. DATE SIGNED: 10/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct.4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Filer IOOF Cemetery
24d. LOCATION (City, town, or county) (State): Filer, Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 10-3-69
REGISTRAR'S SIGNATURE: Vera Ryals
25. EMBALMER: Ronald J. Hamilton
LICENSE NO.: E-470

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary Twin Falls,

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
BIRTH NO OCT 17 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4895
Local Reg. No. D-339
Reg. Dist. No. 460

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
c. LENGTH OF STAY (In this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mountain View Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): R.F.D. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ERNEST	L.	PETERSON	Oct.	1	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Nov. 10, 1884	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Sweden	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ludwig Peterson	Sweden	No Record	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-42-5489	Ralph V. Peterson RFD #1	Buhl, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Sudden / Several years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3-21, 1960, *to* 10-10, 1969, *that I last saw the deceased alive on* 9/16, 1969, *and that death occurred at* 1:50 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. G. McCluskey MD	Twin Falls Idaho.	10/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/4/69	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13, 1969	Marva D. Marsh	George Farmer	E-480

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

OCT 17 1969

MAR 31 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 15 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4896
Local Reg. No. D - 332
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls OCT 9 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. Magic Valley Mem. Hosp. 43

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY King 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Seattle
d. STREET ADDRESS (If rural, give location) 105 14th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) DORIS
b. (Middle) J.
c. (Last) ROBBINS

4. DATE OF DEATH (Month) (Day) (Year) October 1, 1969

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH August 28, 1940
9. AGE (In years last birthday) 29
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) El Dorado, Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Goodwin
BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME unknown
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE James C. Reynolds, ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5718

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Thanerosis (Fat) Liver Exterior
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroner's investigation, only, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 7:34 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Gloria O. Edwards 583 (Degree or title) Coroner
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 10/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 10/4/69
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Seattle, Washington

DATE REC'D BY LOCAL REG. Oct. 7, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER James C. Reynolds
LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 10 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 6 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to'

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 4897
Local Reg. No. D-333
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 42 OCT 9 1969
b. CITY OR TOWN Twin Falls | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13 b. COUNTY T. Falls 420
c. CITY OR TOWN Rural Kimberly
d. STREET ADDRESS R.R.#2

3. NAME OF DECEASED (Type or Print) a. (First) JESSIE b. (Middle) c. (Last) LARK
4. DATE OF DEATH (Month) (Day) (Year) October 3, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 6
8. DATE OF BIRTH 6-17-1883
9. AGE (In years last birthday) 86 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unkown BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unkown BIRTHPLACE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-60-8440 T
17. INFORMANT'S OWN SIGNATURE R.R.# 2 Kimberly, Idaho ADDRESS

MEDICAL CERTIFICATION

4189

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occulusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis, Generalized — 20 yrs.

DUE TO (c) Severe Rheumatoid Arthritis — 20 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 19 51, *to* Oct. 3, 1969, *that I last saw the deceased alive on* Oct. 3, 1969, *and that death occurred at* 9:05a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) O. Ellis Knight M.D.
23b. ADDRESS 210 Chestnut St. Nth Kimberly, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-6-1969
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Oct. 8, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Paul D. Reynolds
LICENSE NO. E-495
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED OCT 13 1969 Bureau of Vital Statistics

State File No. 4898
Local Reg. No. D-336
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 226 Adams St.

3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) J. c. (Last) RICE

4. DATE OF DEATH (Month) (Day) (Year) Oct. 3, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Aug. 30, 1895

9. AGE (In years last birthday) 74
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Livestock dealer

10b. KIND OF BUSINESS OR INDUSTRY Livestock

11. BIRTHPLACE (State or foreign country) Hunningburg, Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME unknown
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME unknown
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WWI 3

16. SOCIAL SECURITY NO. 563-20-3705

17. INFORMANT'S OWN SIGNATURE Sarah E. Rice
ADDRESS Twin Falls, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: one second

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pnuemonia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-14, 1965 to 10-3-, 1969, that I last saw the deceased alive on 10-3-, 1969 and that death occurred at 12 noon from the causes and on the date stated above.

23a. SIGNATURE A. M. Kendall M.D. (Degree or title)

23b. ADDRESS 206 Martin St. Twin Falls

23c. DATE SIGNED 10-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/6/1969

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Oct. 9, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Edgar J. Robertson

LICENSE NO. E-507

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969

MAR 11 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4899
Local Reg. No. D-334
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
OCT 13 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic & Hosp. 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer 83328
d. STREET ADDRESS (If rural, give location): 218 5th Street

3. NAME OF DECEASED (Type or Print): a. (First) IRMA b. (Middle) ESTELLA c. (Last) SHOWERS

4. DATE OF DEATH: (Month) Oct. (Day) 3, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 31, 1897

9. AGE (In years last Birthday): 72
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Climax, Michigan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clarence E. Deal
BIRTHPLACE: Mich.

14. MOTHER'S MAIDEN NAME: Stella McDiarmid
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT'S OWN SIGNATURE: Clarence E Showers
ADDRESS: Michigan

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 1540 Adeno Carcinoma Rect-Sigmoid — INTERVAL BETWEEN ONSET AND DEATH: 9 Months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Decreased Arterio Sclerosis — 1-2 yrs.
DUE TO (c): Pulmonary Emphysemia —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Nutritional Deficiency — Several months
Marked Secondary Anemia —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-29, 1969, to 10-3, 1969, that I last saw the deceased alive on 10-3, 1969, and that death occurred at 12:45a.m. from the causes and on the date stated above.

23a. SIGNATURE: D.A. McCluskey M.D. 338 (Degree or title)

23b. ADDRESS: Twin Falls Idaho

23c. DATE SIGNED: 10/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/6/1969

24c. NAME OF CEMETERY OR CREMATORY: Filer IOOF Cemetery

24d. LOCATION (City, town, or county) (State): Filer, Idaho

DATE REC'D BY LOCAL REG.: Oct. 9, 1969

REGISTRAR'S SIGNATURE: Marva O. Mush

25. EMBALMER: Ronald J. Hamilton

LICENSE NO.: E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

MAR 2 0 1970

MAY 1 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 2 7 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 4 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

APR 7 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

BIRTHS OCT 17 1969

Certificate of Death
STATE OF IDAHO

State File No. 4900
Local Reg. No. D-338
Reg. Dist. No. 460

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH — Bureau of Vital Statistics — Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 12 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): R.F.D. # 4--Peck Addition

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES; b. (Middle) E.; c. (Last) BURBANK
4. DATE OF DEATH: (Month) Oct. (Day) 4 (Year) 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 13, 1914
9. AGE (In years last birthday): 54
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Officer 08
10b. KIND OF BUSINESS OR INDUSTRY: Law Enforcement
11. BIRTHPLACE (State or foreign country): Nebraska City, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Burbank — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Stella Fischer — BIRTHPLACE: Nebraska
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 518-09-1272
17. INFORMANT'S OWN SIGNATURE: Ollie A Burbank — ADDRESS: RFD # 4 Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Infarction of Myocardium — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) due to Coronary Sclerosis — 11 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 23, 1969, to Oct 4, 1969, that I last saw the deceased alive on Oct 3, 1969, and that death occurred at 8:29 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Vern H Henderson M.D.
23b. ADDRESS: Buhl, Ida
23c. DATE SIGNED: 10-10-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/7/69
24c. NAME OF CEMETERY OR CREMATORY: Buhl
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: Oct. 13, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Robert L. Dickard
LICENSE NO.: E-312

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

OCT 17 1969
OCT 21 1969
NOV 12 1969
DEC 3 1975
JAN 14 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4901
Local Reg. No. D-337
Reg. Dist. No. 460

BIRTH NO.

OCT 13 1969

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 421 Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give) Twin Falls

c. LENGTH OF

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sky View Mannor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY Twin Falls 421

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

d. STREET ADDRESS (If rural, give location) Filer Avenue West

3. NAME OF DECEASED (Type or Print)

a. (First) Betsy

b. (Middle) Millington

c. (Last) Cherry

4. DATE OF DEATH (Month) (Day) (Year) Oct 4, 1969

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov 18, 1874

9. AGE (In years last birthday) 94 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Treasureton, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Millington — BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Hannah Sant — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-12-5458T

17. INFORMANT'S OWN SIGNATURE Eph Johnson — ADDRESS Preston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Age 95 Old age senility Gen debility

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Gen Arteriosclerosis

Cardio Vascular Renal Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 19 68 *19* Oct *, 19* 69 *that I last saw the deceased alive on* 9-13-1969*, and that death occurred at* Oct 4 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M A Drake MD 146

23b. ADDRESS 94 Hazelwood Ave

23c. DATE SIGNED Feb 7 63

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE Oct 8, 1969

24c. NAME OF CEMETERY OR CREMATORY Hyde Park, Cemetery

24d. LOCATION (City, town, or county) (State) Hyde Park, Utah

DATE REC'D BY LOCAL REG. Oct. 9, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Edgar J. Robertson

LICENSE NO. E-507

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4902
Local Reg. No. D-342
Reg. Dist. No. 460

BIRTH NO.

OCT 17 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly 83341
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic & Hosp. 144	d. STREET ADDRESS (If rural, give location) Van Buren St. W.

3. NAME OF DECEASED (Type or Print) a. (First) JOSH	b. (Middle) H.	c. (Last) ELLER		4. DATE OF DEATH (Month) (Day) (Year) Oct. 4, 1969	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan. 9, 1884	9. AGE (In years last birthday) 85	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Smith Co, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur H. Eller	BIRTHPLACE Missouri		14. MOTHER'S MAIDEN NAME Salina Swain	BIRTHPLACE unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) ----	16. SOCIAL SECURITY NO. 519-016349	17. INFORMANT'S OWN SIGNATURE Russell L. Eller	ADDRESS Kimberly	

18. CAUSE OF DEATH 4409
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiovascular Collapse	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized Arterio Sclerosis	2 years
DUE TO (c)	Senile Dementia	1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Prostate Hypertrophy c̄ Urinary Retention	Several months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 3-3-62, 19__, *to* 10-4-69, 19__, *that I last saw the deceased alive on* 10-4-69, 19__, *and that death occurred at* 10:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE 338 D. McCluskey MD (Degree or title)	23b. ADDRESS Twin Falls Ida.	23c. DATE SIGNED 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 7, 1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Oct. 14, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Edgar J Robertson	LICENSE NO. E-507

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 0 5 1992
APR 1 0 1992

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4903
Local Reg. No. D-335
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421 OCT 13 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place) Bureau of Vital Statistics	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143	d. STREET ADDRESS (If rural, give location) Clinton Drive Route #1

3. NAME OF DECEASED (Type or Print) a. (First) TERRY	b. (Middle) DAVID	c. (Last) STANSELL	4. DATE OF DEATH (Month) (Day) (Year) Oct. 4, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan. 8, 1958	9. AGE (In years last birthday) 11 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Stansell	BIRTHPLACE Idaho	14. MOTHER'S MAIDEN NAME Norma Fonley	BIRTHPLACE Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S OWN SIGNATURE x David Stansell	ADDRESS Twin Falls, Id.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8/21

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral edema; Herniation of uncal gyrus. — INTERVAL BETWEEN ONSET AND DEATH 7 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Concussion Fracture of Rt Frontal bone

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute pneumonia.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify) 1	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) County Road 06	21c. (CITY, TOWN, OR TOWNSHIP) 3420 Twin Falls (COUNTY) Twin Falls (STATE) Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21f. HOW DID INJURY OCCUR? Auto Accident-Collision	

22. *I hereby certify that I attended the deceased from* 9/29 *19*69*, to* 10/4 *, 19*69*, that I last saw the deceased alive on* 10/4 *, 19*69*, and that death occurred at* 2:35P *m., from the causes and on the date stated above.*

23a. SIGNATURE E. M. Wright 576	(Degree or title) MD.	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 10/6/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/7/1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho
DATE REC'D BY LOCAL REG. Oct. 9, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Jerry D. Holman	LICENSE NO. E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 14 1965

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4904
Local Reg. No. D-341
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer, 83328
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 609 West Main

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer 83328
d. STREET ADDRESS (If rural, give location): 609 West Main

3. NAME OF DECEASED (Type or Print): a. (First) ROSA; b. (Middle) DALE; c. (Last) HUDSON

4. DATE OF DEATH: (Month) Oct. (Day) 6, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 10, 1878

9. AGE (In years last birthday): 91
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNK
BIRTHPLACE: UNK

14. MOTHER'S MAIDEN NAME: UNK
BIRTHPLACE: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT'S OWN SIGNATURE: X Lucile H. Baird
ADDRESS: Filer, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio-sclerotic Cardio Vascular Disease — 15 to 20 yrs
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 13, 1963, to Oct. 6, 1969, that I last saw the deceased alive on Sept. 19, 1969, and that death occurred at 8:06 p.m., from the causes and on the date stated above.

23a. SIGNATURE: Edward A Rees (Degree or title) M D
23b. ADDRESS: Twin Falls Idaho
23c. DATE SIGNED: 10-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: October 14, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Ronald J. Hamilton
LICENSE NO.: E470

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 1 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4905
Local Reg. No. D-347
Reg. Dist. No. 460

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420 OCT 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give [illegible]) Filer (rural) Bureau of Vital Statistics
c. LENGTH OF [illegible] place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 1 No. Filer 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer (rural) 83328
d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First) Albert
b. (Middle) Robert
c. (Last) Lierman

4. DATE OF DEATH (Month) (Day) (Year) Oct. 7, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH July 27, 1894
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY agriculture
11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Albert Lierman — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Clara Werner — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. 519-38-5418
17. INFORMANT'S OWN SIGNATURE x Hulda M. Lierman — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infarction of Mycardium due to coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: a few hrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic Heart Disease — sev. yrs
DUE TO (c) Old Coronary Thrombosis in 1963

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 2, 1969, *to* Oct 7, 1969 *that I last saw the deceased alive on* Oct 3, 1969 *and that death occurred at* about *m., from the causes and on the date stated above.*

23a. SIGNATURE Vern H Anderson (Degree or title) 01
23b. ADDRESS 5 PM Buhl, Idaho
23c. DATE SIGNED 10-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 10-10-69
24c. NAME OF CEMETERY OR CREMATORY Clover Cemetery
24d. LOCATION (City, town, or county) Filer, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 15, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Dale Patterson — LICENSE NO. E-451

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1969

APR 23 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4906
Local Reg. No. D-340
Reg. Dist. No. 460

69-10703 RECEIVED

BIRTH NO.

OCT 17 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY IDAHO 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Haoptial 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 235 3rd. Street East

3. NAME OF DECEASED (Type or Print) a. (First) INFANT b. (Middle) VERN c. (Last) WAYNE HOOBLER

4. DATE OF DEATH (Month) (Day) (Year) October 8, 1969

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Oct. 8, 1969

9. AGE (In years last birthday) IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours 2 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME FLOYD HOOBLER BIRTHPLACE IDAHO

14. MOTHER'S MAIDEN NAME PAULA J. VILLERS BIRTHPLACE IDAHO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT'S OWN SIGNATURE X Pauline Villers ADDRESS TwinFalls, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7762

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Infant Respiratory distress sundrome — INTERVAL BETWEEN ONSET AND DEATH 24hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity — 24hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/8, 19 69, *to* 10/8, 19 69, *that I last saw the deceased alive on* 10/8, 19 69, *and that death occurred at* 11:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE Tom Wright 576 (Degree or title) MD

23b. ADDRESS Twin Falls Idaho

23c. DATE SIGNED 10/9/69.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 11, 1969

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Oct. 14, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Jerry D. Holman

LICENSE NO. E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4907
Local Reg. No. D-343
Reg. Dist. No. 460

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 42 OCT 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION T. F. Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420
a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 Route #2
d. STREET ADDRESS (If rural, give location) Rural 4miles so. ½ West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOSEPHINE	MAY	RAMSEYER	October 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Caucasian	Married	Jan. 25, 1924	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	Smith Center, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John C. Jones	Missouri	Velora T. Cherrington	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519-14-7073	Donald D Ramseyer	Twin Falls, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1929 Glioblastoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Dec. 1968	Glioblastoma, inoperable	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2/27 1969 to 10/8 1969, that I last saw the deceased alive on 10/8 1969, and that death occurred at 11:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George W. Warner Jr. SST	Twin Falls, Ida	10/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 11, '69	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 14, 1969	Marva D. Marsh	Jerry D. Holman	E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969
DEC 18 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

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ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED OCT 23 1969 Bureau of Vital Statistics

State File No. 4908
Local Reg. No. D-350
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
STAY (in this place): 90 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Multnomah 335
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Portland
d. STREET ADDRESS (If rural, give location):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazel Del Manor 285

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Vella		Parberry	Oct. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Oct. 17, 1885	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife 01	Own home	Filley, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Noble	Missouri	Margaret Vance	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	521-14-2225	x Mrs. Ralph Baughman	Buhl, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congestive heart failure, progressive	1 yr.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic heart disease	5 yr.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* 1.	Cerebrovascular arteriosclerosis	5 yr.
2.	Cerebral thrombosis	4 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-17, 19 64, *to* 10-9-, 19 69, *that I last saw the deceased alive on* 10-9, 19 69, *and that death occurred at* 2:40 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James H. Robertson MD	Twin Falls, Idaho	10-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Oct. 13, 1969	Buhl Cemetery	Buhl	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1969	Marion D. Marsh	Jim A. Hopkins	E-482

FIRM NAME: Hopkins-Buhl Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4909
Local Reg. No. D-344
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Twin Falls 42

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho 13

b. COUNTY: T. Falls 42

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

d. STREET ADDRESS (If rural, give location): 1954 Maple Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	FRANCIS	EMIL	DIDIER	October 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 1, 191 6	53		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 34	Ida-Gem Dairymen	Osage City, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fernan Didier	France	Emma Rouviere	Osage City, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes W.W. #2	509-07-4845	Mrs Francis Didier	1954 Maple Ave E.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction 4109	4 weeks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/12, 1969 *to* 10/10/, 1969, *that I last saw the deceased alive on* 10/9, 1969 *and that death occurred at* 8:20a.m., *from the causes and on the date stated above.*

23a. SIGNATURE		23b. ADDRESS	23c. DATE SIGNED
	418 (Degree or title) M.D.	Twin Falls, Idaho	10/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/13/69	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 14, 1969	Marva D. Marsh	Paul D. Reynolds	E-495

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Reynolds Funeral Chapel

OCT 17 1969

OCT 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4910
Local Reg. No. D-349
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
OCT 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 157 Alexander Street 800

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 157 Alexander Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MELVINA	CLAIRE	NAVIN	October 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Caucasian	Married	Nov. 4, 1903	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Nezperce, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
FRED WILLIAM GLENN	Missouri	LILLIE ANDERSON	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-10-8182	T. Herold Navin	Twin Falls Id.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/22

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral vascular accident — 3-1/2 yrs.
DUE TO (c) Hypertensive cardiovascular disease — 2 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 12, 1964, to October 10, 1969, that I last saw the deceased alive on October 10, 1969, and that death occurred at 10:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Willard N. Clarke MD	632 Main Av. N., Twin Falls	10/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 13, 1969	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 17, 1969	Marna D. Marsh	Edgar J. Robertson	E-507

FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4911
Local Reg. No. D-346
Reg. Dist. No. 460

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls OCT 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Twin Falls
c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Twin Falls
d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print) a. (First) LOUISE b. (Middle) MARIE c. (Last) SOMMER

4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 29, 1896

9. AGE (In years last birthday) 73
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Homemaking

11. BIRTHPLACE (State or foreign country) Monroe, Wisconsin

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jakob Steinmann
BIRTHPLACE Switzerland

14. MOTHER'S MAIDEN NAME Marie Schnyder
BIRTHPLACE Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ----

16. SOCIAL SECURITY NO. 519-40-6866B

17. INFORMANT'S OWN SIGNATURE X Helen E. Sommer
ADDRESS Twin Falls, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4272

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congenital heart disease — unknown years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 11, 1969 *to* October 11, 1969, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ *h., from the causes and on the date stated above.* Regular doctor was out of town.

23a. SIGNATURE (Degree or title)

23b. ADDRESS 204 4th Ave. E. Twin Falls, Ida.

23c. DATE SIGNED 10/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/14/1969

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Oct. 15, 1969

REGISTRAR'S SIGNATURE Marva D Marsh

25. EMBALMER

LICENSE NO. E-516

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969
OCT 14 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4912
Local Reg. No. D-352
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls (421) OCT 27 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Twin Falls
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp. (143)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls (421)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 146 Addison Ave. West

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN		HANEY	Oct. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	never married	Oct. 24, 1890	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Business Mgr. 26	Carnival	Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
no record		no record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
unkn.		527-01-2991	x Joe P Williams	Twin Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cardiac decompensation — 1 week

DUE TO (c) Generalized arteriosclerosis — 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-27-67 19___, *to* 10-11-69 19___, *that I last saw the deceased alive on* 10-11-69 19___, *and that death occurred at* 2:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Willard H. Clark MD	Twin Falls, Idaho	10-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	10-15-69	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-24-69	Vera Royals	Dale Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-6302

DUTIES:

DEC 22 1959

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. R. A. Drake

Certificate of Death
STATE OF IDAHO

RECEIVED OCT 20 1969 Bureau of Vital Statistics

State File No. 4913
Local Reg. No. D-348
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls — c. LENGTH OF STAY (In this place): 2 yrs	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazel Del Manor 285	d. STREET ADDRESS (If rural, give location): 318 Utah St.

3. NAME OF DECEASED (Type or Print)	a. (First) Bertha	b. (Middle) M.	c. (Last) Thomason	4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Jan. 14, 1890	9. AGE (In years last birthday): 79 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Domestic	11. BIRTHPLACE (State or foreign country): Harrison, Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Arter Studyvin	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Phebie Love	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ----------	16. SOCIAL SECURITY NO.: 518-22-7983-B	17. INFORMANT'S OWN SIGNATURE: Marvin Thomason	ADDRESS: Gooding, Ida.	

4389

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Terminal Bronchopneumonia body

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) old age Gen arteriosclerosis
DUE TO (c) hemiplegia

INTERVAL BETWEEN ONSET AND DEATH: years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1968, 19__, *to* Oct 11, 1969, *that I last saw the deceased alive on* Oct 11, 1969 *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE: R. A. Drake 146 (Degree or title) M.D.	23b. ADDRESS: 594 Hazel del Manor	23c. DATE SIGNED: 9-14-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3	24b. DATE: 10-15-1969	24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery	24d. LOCATION (City, town, or county): Gooding, (State): Idaho
DATE REC'D BY LOCAL REG.: Oct. 16, 1969	REGISTRAR'S SIGNATURE: Marva D. Marsh	25. EMBALMER: Eddie [illegible]	LICENSE NO.: E-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4914
Local Reg. No. D-345
Reg. Dist. No. 46C

BIRTH NO.

RECEIVED
OCT 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Grandview Dr.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): Grandview Dr.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DANNIE		CARLSON	Oct. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	Sept. 27, 1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor	Custodial	Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	512-10-0840	X Wanda F. McCormick	Twin Falls, Id.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cardiac arre st — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary insufficiency
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* CORONERS INVESTIGATION ONLY *, 19____, to , 19____, that I last saw the deceased alive on , 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Loyce O. Edwards	Coroner	R#3 Twin Falls, Ida	Oct 15-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	Oct. 16, 1969	Mt. View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 15, 1969	Marva D. Marsh	Ronald J. Hamilton	E-470

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 17 1969
OCT 21 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4915
Local Reg. No. D 373
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (In this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 416 14th Avenue North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THELMA	W.	LEE	October 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	April 28, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Alamogordo, New Mexico	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter W. Whitmire	Arkansas	Cora Smith	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
No	519-52-6904	Ernest H. Lee, 416 14th N Buhl, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of Gallbladder and liver — INTERVAL BETWEEN ONSET AND DEATH: 1-29-69 to 10-12-69

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.
Malnutrition
Severe Jaundice
3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-29-69, 19____, *to* 10-12-69, 19____, *that I last saw the deceased alive on* 10-10, 1969, *and that death occurred at* 8:35 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern Henderson, M.D.	Buhl, Idaho	10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/15/69	Buhl	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Maura D. Mark	George Farmer	E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4916
Local Reg. No. D-353
Reg. Dist. No. 46

BIRTH NO.

RECEIVED OCT 27 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1944 Maple

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). 421
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 1944 Maple

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MAMIE	ETHEL	CARVER	October 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	March 25, 1903	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant 22	Variety Store	Eden, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Virgil B. Stallings	Utah	Isabel Burnett	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	521-26-4511	James Harry Carver	Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1530

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of ascending colon — months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 11, 19 66, *to* Oct. 13, 19 69, *that I last saw the deceased alive on* October 13 19 69, *and that death occurred at* 1:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	a 122 9th No. Buhl, Idaho	10-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 16, 1969	Sunset Mem. Park	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-24-69	Vera Ryals	William J. Boyd	E-490

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-630 21

OCT 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 1 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4917
Local Reg. No. D-354
Reg. Dist. No. 460

BIRTH NO. OCT 27 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Bureau of Vital Statistics Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (In this place) Years
d. FULL NAME OF HOSPITAL OR INSTITUTION R.F.D. # 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) R.F.D. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RANKIN		RUTHERFORD	October 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 4, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheepman	Livestock	Telico Plains, Texas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John F. Rutherford	Tennessee	Malinda Williams	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-46-4613	Mrs Esther Rutherford	Buhl Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

2509

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Uremia. — INTERVAL BETWEEN ONSET AND DEATH: 5 mon.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nephrosclerosis.
DUE TO (c) Diabetes Mellitus — 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Prostatic Insufficiency, Osteoarthritis Emphysema. Carcinoma, benign Prostatic Hypertrophy

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	AUTOPSY? Yes / No
		No X

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7/3, 19 69, *to* Oct 16, 19 69, *that I last saw the deceased alive on* Oct 9, 19 69, *and that death occurred at* 8:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Roy C. Shaub M.D.	284 Main St. T.F. Idaho	10/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/18/69	Buhl	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-24-69	Vera Ryals	George Farmer	E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 2 6 1969

JUN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4918
Local Reg. No. D-351
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls — OCT 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics): Twin Falls 83301
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 156 Polk St.

3. NAME OF DECEASED (Type or Print)
a. (First): ORVILLE
b. (Middle): WINFIELD
c. (Last): REYNOLDS

4. DATE OF DEATH (Month) (Day) (Year): October 18,1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 21,1906
9. AGE (In years last birthday): 63
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian
10b. KIND OF BUSINESS OR INDUSTRY: Church
11. BIRTHPLACE (State or foreign country): Ashe County, No. Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Pinkney Hubryson Reynolds — BIRTHPLACE: Tennessee
14. MOTHER'S MAIDEN NAME: Amanda Cora Alice Price — BIRTHPLACE: Ashe Co. N. Ca.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 549-28-2285
17. INFORMANT'S OWN SIGNATURE: Bertha Reynolds — ADDRESS: (same)

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic coronary A. Disease — years
DUE TO (c): Chronic Lymphatic Leukemia — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 4 , 19 60 *to* October 18 , 19 69 , *that I last saw the deceased alive on* October 18 , 19 69 , *and that death occurred at* 9:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dean H. Appleck M.D.
23b. ADDRESS: 231 4th Avenue North, Twin Falls, Idaho
23c. DATE SIGNED: 21 Oct. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10.21.69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: Oct. 23,1969
REGISTRAR'S SIGNATURE: Vera Ryals
25. EMBALMER: Jerry D. Holman
LICENSE NO.: E-516
FIRM NAME: White Mortuary Twin Falls, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

OCT 27 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 10 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4919
Local Reg. No. D-368
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (in this place): 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 820 Sprague

3. NAME OF DECEASED (Type or Print): a. (First) Lauvisia b. (Middle) Bessie c. (Last) Crist

4. DATE OF DEATH: (Month) Oct (Day) 26, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	June 5, 1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	Own home	Shoshone, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Chriswell	Kansas	Rose Julia	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-20-6693A	Verna Fairchild, Mrs.	Buhl, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Congestive heart failure	months
DUE TO (c)	Chronic pyelitis	months
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerotic heart disease	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-21, 1962, *to* 10-26, 1969, *that I last saw the deceased alive on* 10-26-69, 19__, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	122 9th Ave. No. Buhl, Idaho	10-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 29, 1969	Buhl Cemetery	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1969	Marva D. Marsh	John A Hopkins	E-482

FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4920
Local Reg. No. D-355
Reg. Dist. No. 460

Certificate of Death

RECEIVED
NOV 4 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 83328
d. STREET ADDRESS (If rural, give location) 126 Main

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) WILLIAM
c. (Last) LAMP

4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Sept. 23, 1901
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Ranching
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Fred Lamp
BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME no record
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - - - - -
16. SOCIAL SECURITY NO. 518-22-8929
17. INFORMANT'S OWN SIGNATURE Fred E. Lamp
ADDRESS Filer, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3482

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PROGRESSIVE MUSCULAR ATROPHY — INTERVAL BETWEEN ONSET AND DEATH 2 YRS.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-16, 1966, *to* 10-26, 1969, *that I last saw the deceased alive on* 10-26, 1969, *and that death occurred at* 8:20a *m., from the causes and on the date stated above.*

23a. SIGNATURE V. V. Telford 525 (Degree or title) MD
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 10-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 10-31-69
24c. NAME OF CEMETERY OR CREMATORY Filer I.O.O.F. Cemetery
24d. LOCATION (City, town, or county) Filer, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 31, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER William J. Boyd
LICENSE NO. E-490

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: NOV 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4921
Local Reg. No. D-369
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (In this place): 3 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 819 Sprague Avenue

3. NAME OF DECEASED (Type or Print): a. (First) MYRTLE; b. (Middle); c. (Last) MOORE

4. DATE OF DEATH (Month) (Day) (Year): October 27 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 29, 1891

9. AGE (In years last birthday): 78
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Viola, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Georg e W. McCullaugh
BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Nancy Ann Hale
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519-01-0792 D

17. INFORMANT'S OWN SIGNATURE: Gelda Boozer
ADDRESS: RFD # 4 Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 12, 1968, *to* Oct. 27, 1969, *that I last saw the deceased alive on* Oct. 22, 1969, *and that death occurred at* 11:10 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. McCullough MD

23b. ADDRESS: 122 9th Ave. No. Buhl, Idaho

23c. DATE SIGNED: 10-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/31/69

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county): Twin Falls,

(State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 6, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: George Farmer

LICENSE NO.: E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4922
Local Reg. No. D-360
Reg. Dist. No. 46

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls (421)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital (145)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (421)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 587 Highland Avenue

3. NAME OF DECEASED (Type or Print): a. (First) DOROTHY; b. (Middle) MAE; c. (Last) MORRIS

4. DATE OF DEATH (Month) (Day) (Year): October 27, 1969

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: May 1, 1911

9. AGE (In years last birthday): 58
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (02)

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Oscar Doxrude
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Clara Preckel
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 530-30-8839

17. INFORMANT'S OWN SIGNATURE: * Edna M Manske
ADDRESS: I. F.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 5532 Calculus of Small Intestine — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gangrene of Small Intestine
DUE TO (c) Mechanical Band of Bridin — 10 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cirhosis of Liver

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Large Central Hernia.

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 4/15, 1969, *to* 10/27, 1969, *that I last saw the deceased alive on* 10/26/, 1969, *and that death occurred at* 4:05A *m., from the causes and on the date stated above.*

23a. SIGNATURE AND (Degree or title): 515 [signature]

23b. ADDRESS: 204 4th Ave. E. Twin Falls, Ida.

23c. DATE SIGNED: 10/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 30, 1969

24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 11-5-69

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER: Ronald D. Hamilton

LICENSE NO.: E-470

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 7 1969

JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 13 1969 Bureau of Vital Statistics

State File No. 4923
Local Reg. No. D-335
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural -Twin Falls

LENGTH OF STAY (In this place)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hollister - Rural

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 1

d. STREET ADDRESS (If rural, give location) Hollister

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
KATHRINE	MULLIKIN		Oct. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	Divorced	May 18, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Homemaking	Columbus, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----		Alice Turley	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac arrhythmia — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Coroner's investigation only, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Floyd O. Edwards	Coroner	R#1 Twin Falls, Ida.	Oct 30-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 5, 1969	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 12, 1969	Marna D. Marsh	Edgar J. Robertson	E-507

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4924
Local Reg. No. D-367
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Twin Falls 420

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly 83341

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOME...Center Street East 720

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420

a. STATE: Idaho

b. COUNTY: Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly 83341

d. STREET ADDRESS (If rural, give location): Center Street East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY	LUCILLE	MURRAY	October 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Caucasian	Married	Aug. 24, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Homemaking	Fulton, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harry Wallace	Pennsylvania	Carry N. Gringrich	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-42-1808-B	X C. P. Murray	Kimberly, Id.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

"This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: --

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease — 5 yrs.

DUE TO (c) Hypertensive Cardio Vascular Disease — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19 62, *to* October 27, 19 69, *that I last saw the deceased alive on* October 27, 1969, *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. Wilbur Knight MD	Kimberly, Idaho	10-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 31, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-5-69	Vera Ryals	Donald J. Hamilton	E-470

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
NOV 12 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4925
Local Reg. No. D-374
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho b. COUNTY: Twin Falls 420

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (In this place): 29 years

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl

d. FULL NAME OF HOSPITAL OR INSTITUTION: R.F.D. # 2 000

d. STREET ADDRESS (If rural, give location): R.F.D. # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MYRTLE	E.	LAMMERS	Oct. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	July 6, 1898	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife D1	Own Home	Chillicothe, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William SMeary	Missouri	No Record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-40-6386D	W. T. Lammers	RFD # 2 Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Prob. Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — several yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Cerbral Ischemia as shown by freq. weak spells about 3 months attacks of dyspnea

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* 10-29, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 9:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H Anderson, M.D.	Buhl, Ida	11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/1/69	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Maria D. Marsh	George Farmer	E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4926
Local Reg. No. D-358
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls (Rural)
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Highway 50 East of Twin Falls 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 304 North Ostrander

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MICHAEL	PAUL	HOPPER	Oct. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Aug. 18, 1949	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	College	Wendell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roy Hopper	Missouri	Alma Fischer	So. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 60 3314	X Freda Fischer	Jerome, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive Head Trauma — INTERVAL BETWEEN ONSET AND DEATH: INSTANT

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway # 50 06	Twin Falls (RURAL) 13420 Twin Falls, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Oct. 30, 1969 4:30PM		Auto accident

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:30P m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Cloyce O. Edwards 333 4 (Degree or title) Coroner	RH3 Twin Falls Ida	Oct 30-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov. 3, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 4, 1969	Marva D. Marsh	W. L. Hove	E-431

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4927
Local Reg. No. D-365
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 6 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143	d. STREET ADDRESS (If rural, give location) 185 Ramage

3. NAME OF DECEASED (Type or Print)	a. (First) WINIFRED	b. (Middle) KEMPTON	c. (Last) WHITEHEAD	4. DATE OF DEATH (Month) (Day) (Year) October 30, 1969
5. SEX female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 27, 1883	9. AGE (In years last birthday) 85 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Provo, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan E. Kempton	BIRTHPLACE Utah	14. MOTHER'S MAIDEN NAME Mary M.J. Hedenberg	BIRTHPLACE Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-26-4423	17. INFORMANT'S OWN SIGNATURE M. L. Whitehead	ADDRESS Idaho Twin Falls	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH 20 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROSIS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 - 19, 1956, *to* 10 - 30, 1969, *that I last saw the deceased alive on* 10-29, 1969, *and that death occurred at* 7:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE V. V. Pierford 525 (Degree or title) MD.	23b. ADDRESS 153 Blue Lakes Blvd no Twin Falls, Ida.	23c. DATE SIGNED 10-31-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 3, 1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho
DATE REC'D BY LOCAL REG. 11-5-69	REGISTRAR'S SIGNATURE Vera Ryals	25. EMBALMER Ronald J. Hamilton	LICENSE NO. E-470

FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969
JUN 2 2 2012

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. Woodson

Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

State File No. 4928
Local Reg. No. D-370
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION (If outside corporate limits, write RURAL and give township) STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	Ellen	Rowland	Oct. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Mar. 18, 1883	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	Domestic	Silver City, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Gardner	Scotland	Hanna Grundy	Goshen, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	----	518-18-7068	Frances L. Rowland	Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8877

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Fracture Left hip — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Possible stroke
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10/24/69	Intertrochanteric fracture left hip	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	13 Nursing home	Wendell, Ida. 13240

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
10 / 24 / 69 m.		Unknown

22. I hereby certify that I attended the deceased from 10/24/69, 19___, to 10/31, 1969, that I last saw the deceased alive on 10/31, 1969, and that death occurred at 10:25 pm., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
523 H. A. Woodson	MD	676 Shoup Ave W	11/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-1-1969	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1969	Marva D. Marsh	Odie G. Leach	E-511

FIRM NAME Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4929
Local Reg. No. D-359
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421 NOV 6 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 3421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls Bureau of Vital Statistics c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1203 Spruce St. 000	d. STREET ADDRESS (If rural, give location) 120 9th Ave. E.

3. NAME OF DECEASED (Type or Print)	a. (First) JOSEPH	b. (Middle) E.	c. (Last) STAKER	4. DATE OF DEATH (Month) (Day) (Year) Oct. 31, 1969
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 23, 1882	9. AGE (In years last birthday) 87 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Taylor, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Staker	BIRTHPLACE Pennsylvania	14. MOTHER'S MAIDEN NAME Emmaline Swarner	BIRTHPLACE Pennsylvania	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----	16. SOCIAL SECURITY NO. 528-28-9217	17. INFORMANT'S OWN SIGNATURE x Joseph E. Bile	ADDRESS 81 [illegible] Lido Indio Calif.	

18. CAUSE OF DEATH 4369
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral Vascular accident	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11:00 PM (10/31/69), 19____, *to* 11:00 PM (10/31/69), 19____, *that I last saw the deceased alive on* 11 PM 10/31/69, 19____, *and that death occurred at* 11:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Russell W. Newcomb 881 (Degree or title) M.D.	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 11/4/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE Nov. 3, 1969	24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery	24d. LOCATION (City, town, or county) (State) Paul, Idaho
DATE REC'D BY LOCAL REG. 11-5-69	REGISTRAR'S SIGNATURE Vera Ryals	25. EMBALMER Jerry D. Holman	LICENSE NO. E-516

FIRM NAME: Twin Falls, Idaho White Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4930
Local Reg. No. D-367
Reg. Dist. No. 460

RECEIVED NOV 6 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
Length of Stay (in this place): 23 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 242 Third Avenue North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 242 Third Avenue North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HENRY	LEWIS	WURST	October 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 22, 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 64	Ranching	Madrid, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Joseph Wurst	Germany	Teresa Jonda	Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War I 3	519-12-3292	Josephine Wurst	Twin Falls, Ida.

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18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February 25 19 69, *to* October 31 19 69, *that I last saw the deceased alive on* October 17 19 69, *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean H. Affleck MD	231 4th Avenue North Twin Falls, Idaho	Nov. 4, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov. 6, 1969	Hailey Cemetery	Hailey, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 5, 1969	Marva D. Marsh	Stellin J. Boyd	E-490

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 17 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 16 1995

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4931
Local Reg. No. 13
Reg. Dist. No. 310

BIRTH NO.

RECEIVED OCT 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mc Call
c. LENGTH OF STAY (In this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First) C. b. (Middle) Douglas c. (Last) Callaway

4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 7, 1909
9. AGE (In years last birthday) 60 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Ely, Nevada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Callaway BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Minnie E. Johnson BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Nora Callaway ADDRESS Nampa

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occulation — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio vascular disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NATURAL
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Mc Call (COUNTY) Valley (STATE) Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10 - 1 - 1969 2:30 A.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from inspection & physicians records 19 , to 19 , that I last saw the deceased alive on Oct. 1, 1969, and that death occurred at 2:30 A.m., from the causes and on the date stated above.

23a. SIGNATURE Burton E Walker 583 (Degree or title) Coroner
23b. ADDRESS Mc Call Idaho
23c. DATE SIGNED 10-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE 10-6-69
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Oct 5-1969
REGISTRAR'S SIGNATURE Myrtle M. Gardner
25. EMBALMER Burton E Walker
LICENSE NO. E-386

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4932
Local Reg. No. 15
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH 430 OCT 28 1969
a. COUNTY Valley
b. CITY OR TOWN McCall
c. LENGTH OF STAY (in this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Hospital 209

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) Grangeville, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) FRANKLIN b. (Middle) JOSEPH c. (Last) ELLER

4. DATE OF DEATH (Month) (Day) (Year) October 3, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH November 8, 1903

9. AGE (In years last birthday) 65
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21

10b. KIND OF BUSINESS OR INDUSTRY Auto Repair

11. BIRTHPLACE (State or foreign country) Grangeville

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Eller
BIRTHPLACE Arkansas

14. MOTHER'S MAIDEN NAME Bertha Terwillegar
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 518 05 5341

17. INFORMANT'S OWN SIGNATURE Vern Eller
ADDRESS Kamiah, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4442

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis, multiple intraabdominal abscesses — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Massive small bowel infarction — 7 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia — 2½ days.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Small bowel infarction → perforation → peritonitis & abscess

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NA

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) NA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-26-, 1969, *to* 10-3-, 1969, *that I last saw the deceased alive on* 10-3-1969, *and that death occurred at* 9:25 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 931 Edwin J. Droge, M.D.

23b. ADDRESS Box 871 Payette Lakes Med. Clinic McCall, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE oct 8, 1969

24c. NAME OF CEMETERY OR CREMATORY Prairieview

24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Oct-17-1969

REGISTRAR'S SIGNATURE Myrtle M. Gardner

25. EMBALMER Robert R Hansen — Robert R Hansen

LICENSE NO. E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4933
Local Reg. No. 14
Reg. Dist. No. 310

BIRTH NO.

RECEIVED OCT 17 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (In this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location) Box 437

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GEORGE	RAY	PHIPPS	October 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 29, 1903	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer- So. Ida. Timber 17	Protective Ass'n	Council, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Phipps	No. Carolina	Minnie Isabella Heathco	Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-32-4304	A Pauline Phipps	McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebrovascular accident-stroke — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — 10yrs +
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept, 1964 *to* 10-4, 1969, *that I last saw the deceased alive on* 10-4, 1969, *and that death occurred at* 3 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
SDC James H Stewart MD	Cascade Idaho	10-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct 6, 1969	McCall Cemetery	McCall, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct-7-1969	Myrtle M. Gardner	Burton E Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM PH-63031

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics OCT 28 1969

State File No. 4934
Local Reg. No. 16
Reg. Dist. No. 318

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Valley 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) rural
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 21 miles E. Landmark

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY Los Angeles 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Van Nuys
d. STREET ADDRESS (If rural, give location) 5821 Kester Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Austin b. (Middle) Emmett c. (Last) DOROUGH

4. DATE OF DEATH (Month) (Day) (Year) October 4, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 21, 1904
9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Worker 23
10b. KIND OF BUSINESS OR INDUSTRY Disneyland Amusement Park
11. BIRTHPLACE (State or foreign country) Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas J. Dorough
BIRTHPLACE Georgia
14. MOTHER'S MAIDEN NAME Lucy Evans
BIRTHPLACE Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 554-12-6254
17. INFORMANT'S OWN SIGNATURE Donald H Newman
ADDRESS Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CRUSHING INJURIES TO CHEST — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21 mi E. Landmark 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) rural Cascade 13430 Valley Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 4, 1969 6:30 PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY Ooccur? pick-up rolled on victim

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Burton C Walker 583 4 (Degree or title) Coroner
23b. ADDRESS McCall, Idaho
23c. DATE SIGNED 10/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial
24b. DATE Oct. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery
24d. LOCATION (City, town, or county) (State) Los Angeles County, California

DATE REC'D BY LOCAL REG. Oct-16-1969
REGISTRAR'S SIGNATURE Myrtle A Gardner
25. EMBALMER Burton C Walker
LICENSE NO. E-386
FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4935
Local Reg. No. 18
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
NOV 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Valley 52
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
c. LENGTH OF STAY (In this place) 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley Co. Hospital 152

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 501 N. Ash Park Lane

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GEORGIA	MARIE	McBRIDE	Oct. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Oct. 22, 1893	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Goleta, Calif.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mayo S. Currier	Vermont	Cora M. Pierson	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	555-01-8071A	X Mrs Gertrude L. Ott	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4100

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. HYPERTENSION — 15 YRS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes / No
		No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		CASCADE	VALLEY	IDA

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from AUG, 1969, to OCT., 1969, that I last saw the deceased alive on OCT. 10, 1969, and that death occurred at 10A m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John F. Moon 376	M.D	CASCADE, IDA	10/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial 3	10-13-69	Cloverdale Memorial Park	Boise,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov-6-1969	Myrtle H. Gardner	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 4936
Local Reg. No. 7
Reg. Dist. No. 3/0

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Valley (036) — OCT 28 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural, Snowslide Creek area
LENGTH OF STAY (In this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): T. 20 N. R 10 E. SW QTR (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: California (05) b. COUNTY: Del Norte (035)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Crescent City
d. STREET ADDRESS (If rural, give location): Rural Route #2, Box 1356

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	W.	GRAMLICH, SR.	Oct. 16, 1969 (approx)

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	December 25, 1896	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
miner - retired (07)		Sarpy Co., Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis F. Gramlich	Nebraska	Jessie Ellithorpe	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	W W 1 3	522-28-4563	telephone conversation with family	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): severed spinal cord — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): gunshot wound, oral
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

955X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide (2)	Idaho Primitive area (31)	Snowslide Creek area, Valley, Idaho (1350)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Oct 16, 1969 (approx) m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	gunshot wound, self-inflicted

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

INVESTIGATION ONLY

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton E Walker (583 4)	, Coroner	McCall, Idaho	10/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial (3)	Oct 24, 1969	Crescent City Cemetery	Del Norte County, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct-23-1969	Myrtle M. Gardner	Burton E Walker	E-386

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: WALKER FUNERAL HOME

AUG 18 2000 OCT 29 1969

DUTIES: MAR 17 1986

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4937
Local Reg. No. 19
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
NOV 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Valley 430	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho 13 b. COUNTY Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall c. LENGTH OF STAY (In this place) 15 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Meadows
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Lakes Nursing Home 324	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First) JOSEPHINE	b. (Middle) PARLEE	c. (Last) HAMBY	4. DATE OF DEATH (Month) (Day) (Year) October 29, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 4, 1881	9. AGE (In years last birthday) 87 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hiwassee, No. Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton McNabb	BIRTHPLACE no record	14. MOTHER'S MAIDEN NAME Josephine Coleman	BIRTHPLACE no record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 354-10-9536-K1	17. INFORMANT'S OWN SIGNATURE family records	ADDRESS	

4339

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebro vascular accident	2 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral thrombosis	2 hours
DUE TO (c)	Cerebral arteriosclerosis	10 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1965, *to* October 29, 1969, *that I last saw the deceased alive on* October 27, 1969, *and that death occurred at* 6:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Wayne F Allen MD 006 (Degree or title)	23b. ADDRESS McCall, Idaho	23c. DATE SIGNED 11-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE Nov 1, 1969	24c. NAME OF CEMETERY OR CREMATORY Meadows Valley	24d. LOCATION (City, town, or county) (State) Meadows, Idaho

DATE REC'D BY LOCAL REG. Nov-12-1969	REGISTRAR'S SIGNATURE Mayette H. Gardner	25. EMBALMER Burton E Walker	LICENSE NO. E-386

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4938
Local Reg. No. 20
Reg. Dist. No. 320

BIRTH NO.

RECEIVED OCT 21 1969

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Weiser Memorial Hosp. 453

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: Kern 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shafter
d. STREET ADDRESS (If rural, give location): 708 Sycamore St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bertha	---	Lachenmaier	10	15	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	married	June 26, 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Eureka, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ludwig Hoff	South Russia	Magdalena Pfeiffer	South Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Bruce Ioppini by Norma Thomason	Weiser

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 months to 1 year.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 10/15, 1969, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 5:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward Rutledge M.D.	Weiser, Idaho	10/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
rem-burial	10/16/69	Shafter Memorial Park	Shafter, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-16-69	L. Dale Thomason	L. Dale Thomason	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 13 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 11 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4939
Local Reg. No. 21
Reg. Dist. No. 32.6

RECEIVED
OCT 30 1969
Bureau of Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 44
b. CITY OR TOWN: Weiser
c. LENGTH OF STAY: In this place
d. FULL NAME OF HOSPITAL OR INSTITUTION: Weiser Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Washington 44
c. CITY OR TOWN: Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	Albert	Wavrick	10	16	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	caucasian	married	3/4/1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farming 04	agriculture	Elkton, Kentucky	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Wavrick	Austria	Anna Seamen	Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Everett H Montes	Weiser, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4717

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Influenza --
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension Hypertensive Heart Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-9- , 1969, *to* 10-16- , 1969, *that I last saw the deceased alive on* 10-16- , 1969, *and that death occurred at* 6:45P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
344 M.D. McGrath MD	Weiser, Idaho	10/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	10/20/69	Hillcrest Cemetery	Weiser Washington Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-17-69	R. Dale Thomason	R. Dale Thomason	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 3 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 23 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4940
Local Reg. No. 22
Reg. Dist. No. 320

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF TIME (If in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Baker 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Huntington
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print)
a. (First): MISTY
b. (Middle): DAWN
c. (Last): RYNEARSON

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Oct.18, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 12 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Weiser, Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Stephen Rynearson
BIRTHPLACE: Baker, Oregon
14. MOTHER'S MAIDEN NAME: Tena Marie Houser
BIRTHPLACE: Ontario, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Stephen Roy Rynearson
ADDRESS: Huntington, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7791

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature (5½ Mo)

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Premature Separation Placenta

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 18th, 1969, *to* Oct 18, 69, *that I last saw the deceased alive on* Oct 18, 1969, *and that death occurred at* 8 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. S. McGrath MD
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: Oct.18,1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct.21,1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: Oct.18,1969
REGISTRAR'S SIGNATURE: R. Dale Thomason
25. EMBALMER: R. Dale Thomason
LICENSE NO.: E-388

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4941
Local Reg. No. 23
Reg. Dist. No. 320

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington (44) OCT 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital (33)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho (13)
b. COUNTY: Washington (44)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 365 E. Comm.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	JESSE	PERLE	BABCOCK	Oct.	21	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 26, 1882	87	4	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (07)
10b. KIND OF BUSINESS OR INDUSTRY: Ranch
11. BIRTHPLACE (State or foreign country): Pueblo, Colorado
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: George Babcock — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Mary Easton — BIRTHPLACE: New York State

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-07-1074
17. INFORMANT'S OWN SIGNATURE: Mrs. Nellie Babcock — ADDRESS: Weiser

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	C x O x R x	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hypertension	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

4360

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-20-, 1969, *to* 10-21-, 1969, *that I last saw the deceased alive on* 10-21-, 1969, *and that death occurred at* 6:45 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
3+4 M.D. McGrath M.D.	Weiser, Idaho	Oct.21,1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial 3	Oct.23,1969	Riverside Cemetery	Payette	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct.21,1969	L. Lee Thomson	Marshall S. Dickerson Jr.	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: OCT 31 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4942
Local Reg. No. 24
Reg. Dist. No. 320

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Washington 441 — OCT 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser — c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4 E. Galloway OCC

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser,
d. STREET ADDRESS (If rural, give location): 4 E. Galloway

3. NAME OF DECEASED (Type or Print): a. (First) Lowell — b. (Middle) Kenneth — c. (Last) Anderson

4. DATE OF DEATH: (Month) 10 (Day) 27 (Year) 1969

5. SEX: male

6. COLOR OR RACE: caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 12/27/1910

9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dairyman 04

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Cardston, Alberta, Canada

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Hyde Anderson — BIRTHPLACE: --

14. MOTHER'S MAIDEN NAME: Lydia Jane Brown — BIRTHPLACE: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Lowell D. Anderson — ADDRESS: Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

953X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suicide by strangulation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify): Suicide

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 34

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 1944

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroner's investigation, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* approx 12:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Dale Thomason 583 4 Wash. Co. Coroner
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 10/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 10/31/69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser, Wash. Idaho

DATE REC'D BY LOCAL REG.: 10-27-69
REGISTRAR'S SIGNATURE: R. Dale Thomason
25. EMBALMER: Marshall S. Dickenson Jr. E 464
LICENSE NO.

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 13 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 8 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 4943
Local Reg. No. 25
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington — OCT 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 1126 E. Main

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Hazel	Bernice	Pridgen	10	28	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	married	3/31/1917	52				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Shoshone, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Ivie	--	Gladys	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			X	Weiser, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral vascular accident	5 hours
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hypertensive Cardio-vascular disease	years
DUE TO (c)	Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Cerebrosclerosis	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-8-, 19 69, *to* 10-28, 19 69, *that I last saw the deceased alive on* 10/28, 1969, *and that death occurred at* 4:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward R. Meeker MD	Weiser, Idaho	10/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	10/30/69	Hillcrest Cemetery	Weiser Washington Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-28-69	R. Dan Thomson	R. Dan Thomson	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 2 1976

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

JAN 30 1987

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4944
Local Reg. No. 27
Reg. Dist. No. 320

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Park Haven Manor

3. NAME OF DECEASED (Type or Print)
a. (First): Opal
b. (Middle): Faith
c. (Last): Kilborn

4. DATE OF DEATH (Month) (Day) (Year): 10 31 1969

5. SEX: female
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 3/21/1894
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Modesto, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fritz Baird — BIRTHPLACE: ---
14. MOTHER'S MAIDEN NAME: Emma Sims — BIRTHPLACE: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 543 24 7285
17. INFORMANT'S OWN SIGNATURE: X Robert A. Yost — ADDRESS: Payette, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Generalized arteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/28, 1969, *to* 10/31, 1969, *that I last saw the deceased alive on* 10/28, 1969, *and that death occurred at* 4:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edward Pwheeler 901 (Degree or title) MD
23b. ADDRESS: 14 E Idaho Weiser Idaho
23c. DATE SIGNED: 11/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 11/4/69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser Washington Idaho

DATE REC'D BY LOCAL REG.: 11-1-69
REGISTRAR'S SIGNATURE: R. Dale Thomason
25. EMBALMER: R. Dale Thomason — LICENSE NO.: E 388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 5 1969 Bureau of V.S.

State File No. 4945
Local Reg. No. 784
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 4915 State Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Wesley	D.	Lenon	10	25	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan: 19, 1928	41		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician 23
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Gibson, Idaho
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: J.E. Lenon — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Linnie Myrtle — BIRTHPLACE: Blackfoot, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 547-32-4020
17. INFORMANT'S OWN SIGNATURE: Mrs Wesley Lenon — ADDRESS: Same

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH: None

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/25, 1969, *to* 10/25, 1969, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 2:40 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D. 780	312 Idaho	10/28

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-28-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 5, 1969	Myrtle Palmer	Eric B. Bryan	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED OCT 30 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. _____
Local Reg. No. 784
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place): 15 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital	d. STREET ADDRESS (If rural, give location): 4915 State St.

3. NAME OF DECEASED (Type or Print) a. (First): Wesley	b. (Middle): D.	c. (Last): Lenon	4. DATE OF DEATH (Month): 10	(Day): 26	(Year): 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Nov. 24, 1928	9. AGE (In years last birthday): 41	IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Gibson, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: J. E. Lenon	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Linnie Myrtle	BIRTHPLACE: Blackfoot, Idaho		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 547-32-4020	17. INFORMANT'S OWN SIGNATURE: X Mrs Wesley Lenon	ADDRESS		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH: none

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/26, 1969, *to* 10/26, 1969, *that I last saw the deceased alive on* 10/26, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: M D Sawer (Degree or title): MD	23b. ADDRESS: 312 Idaho	23c. DATE SIGNED: 10/28	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10-28-69	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Oct. 28 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Erle B. Byram Erle B. Byram	LICENSE NO.: E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 3 1969

NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 3 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

JUL 1 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 1946
Local Reg. No. 3546
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hammett (Rural)
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CAROL	ANN	WHITTED	October 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		July 14, 1937	32		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	Home	New Mexico	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roy Williamson	Oklahoma	Ruth Carlisle	Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-50-3101	Mrs P.O. Valentine	Cotesby, Okla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8181 Head Trauma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 66	Glenns Ferry, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
10/25/69 7:30PM	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Victim fell from moving car on main highway.

22. *I hereby certify that I attended the deceased from* 10-25, 1969, *to* 10-25, 1969 *that I last saw the deceased alive on* 10-25, 1969, *and that death occurred at* 7:30 PM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Boise, Idaho	11-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 30, 1969	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 25 1969	Myrtle Palmer	H. Vel Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 2 2 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 4947
Local Reg. No. 845
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 306 So. Commercial

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Iva	Anna	Surber	Oct. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married	Feb. 25, 1907	62	8	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Salem, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edwin Hope	Utah	Wilhelmina Klingler	Montpelier, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-18-1443B	X Jane L. M. Jorgen	3034 W. Boise Ave Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1990 Met. Cancer

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Compression of
DUE TO (c) the Spinal Cord

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-24-69	Tumor	Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10-24, 1969, to 10-28, 1969, that I last saw the deceased alive on 10-28, 1969, and that death occurred at 7:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	401 Idaho St	11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 31, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 24, 1969	Myrtle Palmer	Glenn W. Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4948
Local Reg. No. 801
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 12 Randall Street

3. NAME OF DECEASED (Type or Print): a. (First) LEONARD; b. (Middle) PRYOR (RED); c. (Last) SHELTON

4. DATE OF DEATH: (Month) 11; (Day) 1; (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 8/7/1901

9. AGE (In years last birthday): 68
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter 21

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Eldara, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Elmer Shelton, BIRTHPLACE: Pleasant Hill, Ill.

14. MOTHER'S MAIDEN NAME: Martha Eleanor Pryor, BIRTHPLACE: Eldora, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-07-8265

17. INFORMANT'S OWN SIGNATURE: Jack Shelton
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 1579 Carcinoma Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Bleeding Ulcer
Diabetes

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Ca Pancreas

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-31-65, *to* , 19 , *that I last saw the deceased alive on* 10-31, 1969, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. B. Patterson MD

23b. ADDRESS: 1203 BROADWAY

23c. DATE SIGNED: 11-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/3/69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county): Boise, (State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 4, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant

LICENSE NO.: E-478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 4 - 1969

NOV 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 4 - 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 4 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

FEB 20 1979

MAY 7 1981

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4949
Local Reg. No. 806
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 7 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2914 Edson St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ernest		Spitzler	Nov. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Aug. 7, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House painter 21	Painting	Wichita, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Spitzler	Switzerland	Salina	Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-18-4927	A. Mrs Ernest Spitzler	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 185X Granulocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Prostate — 3 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 27, 1969, to 1 November, 1969, *that I last saw the deceased alive on* 31 Oct, 1969, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.		403 Idaho St.	5 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/4/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 7 1969	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 7 - 1969

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 7 1969 Bureau of Vital Statistics

State File No. 4950
Local Reg. No. 808
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes 002	d. STREET ADDRESS (If rural, give location): 2500 Fry St.

3. NAME OF DECEASED (Type or Print)	a. (First) LaVeta	b. (Middle) Idora	c. (Last) Hargrave	4. DATE OF DEATH (Month) (Day) (Year)	Nov. 2, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced	8. DATE OF BIRTH: April 24, 1912	9. AGE (In years last birthday): 57	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Teacher 12	10b. KIND OF BUSINESS OR INDUSTRY: Public Schools	11. BIRTHPLACE (State or foreign country): Pearl, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: Frank Womack	BIRTHPLACE: Idaho	14. MOTHER'S MAIDEN NAME: Minnie Franklin	BIRTHPLACE: Buffalo, Kansas		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 558-32-9444	17. INFORMANT'S OWN SIGNATURE: X Minnie Hargrave	ADDRESS		

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1830

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Hemorrhage	9 hrs. (approx.)
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Metastatic Carcinoma, Cerebral (?)	
DUE TO (c)	Ovarian Carcinoma	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Status, Post-op. Mitral Valve Replacement	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-21, 1969, *to* 11-2, 1969, *that I last saw the deceased alive on* 11-2, 1969, *and that death occurred at* 9:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Rodney H Hen 862 (Degree or title) M.D	23b. ADDRESS: 123 E. Idaho St	23c. DATE SIGNED: 11-5-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 11/6/1969	24c. NAME OF CEMETERY OR CREMATORY: Masonic Cemetery	24d. LOCATION (City, town, or county) (State): Elko, Nevada
DATE REC'D BY LOCAL REG.: Nov. 7 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Earl Waggoner	LICENSE NO.: E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

SEP 19 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4951
Local Reg. No. 147
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011 NOV 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 4 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 604 VETS ADMIN HOSPITAL, BOISE, IDA.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 5501 CRUZEN

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	DARWIN	LATHROP	NOVEMBER 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	APRIL 8, 1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
VETS EMPLOYMENT REP. 08	STATE OF IDAHO	IOWA FALLS, IOWA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
FRANK LATHROP	UNKNOWN	(FIRST NAME UNK.) SWANEY	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII 4	518 07 09 00	Leslie Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Status asthmaticus — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe pulmonary emphysema and chronic bronchial asthma — 25years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from OCTOBER 29, 1969, to NOVEMBER 2, 1969. I last saw the deceased alive on , and that death occurred at 4:42 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O.G. RIML, M.D. 597		VA CENTER, BOISE, IDAHO	11/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/5/1969	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 5 1969	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

5 - (1) Vet

NOV 5 1969
NOV 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4952
Local Reg. No. 824
Reg. Dist. No. 270

BIRTH NO.

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Ada 001

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Ada 001

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 522 Benjamin Lane

3. NAME OF DECEASED (Type or Print)

a. (First): FANNIE

b. (Middle): L

c. (Last): LUNSTRUM

4. DATE OF DEATH: (Month) 11 (Day) 2 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 12/8/1881

9. AGE (In years last birthday): 87

IF UNDER 1 YR. Months / Days:

IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Green Ridge, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Wadleigh

BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Hannah Brewster

BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-42-4649-B

17. INFORMANT'S OWN SIGNATURE: x F. W. Lunstrum

ADDRESS:

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic heart disease — 20 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8 July, 1965, *to* 2 Nov, 19 69, *that I last saw the deceased alive on* 1 Nov, 19 69, *and that death occurred at* 3:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Clayton C Morgan 370 (Degree or title): M.D.

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 6 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-5-1969

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: Nov 14, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Elbert T. Pearson

LICENSE NO.: E-512

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 2 0 1969

MAY 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 1 1 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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S. Jones

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 7 1969 Bureau of Vital Sta

State File No. 4953
Local Reg. No. 807
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital co 3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1617 North 12th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Roy	Francis	Murphy	11	3	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 10, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grocery Bus. 26	Commissioner	Manitowoc, Wisc	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Bernard Murphy	Ireland	Bridget Conroy	West Virg.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-07-0973	Georgia F Murphy	

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c).

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5749

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Paralytic Ileus c profuse emesis c Drowning	3 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Post operative Cholecystectomy 4 days	
DUE TO (c)	Cholelithiasis c Acute Colic	6 mo
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerosis - Depression Shock Therapy.	1 year

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Cholelithiasis	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10/28, 1969, to 11/3, 1969, that I last saw the deceased alive on 11/1, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. Jones Jr MD	Boise Idaho	11/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-6-69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 7 1969	Myrtle Palmer	Edd B. Byram	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

6.c.c

NOV 7 1969

OCT 1 1985

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 8 1969 Bureau of Vital Statistics

State File No. 4954
Local Reg. No. 158
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 209 West 39th Street 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 209 West 39th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GUY	L.	WILLIAMS	Nov. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	March 19, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Same	Ponca City, Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Merton Perl Williams,	Richhill, Mo.	Ester W. Burgoon,	Attawa, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-07-4163	M E. Williams	1805 C Street Butte, Mont.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

162

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1969, to 11/3, 1969, that I last saw the deceased alive on 11/3, 1969, and that death occurred at 3:00P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
MD		12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-6-69	Syringa Gardens	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 5 1969	Myrtle Palmer	Harry A. Coover	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 2 3 1973

MAR 2 5 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4955
Local Reg. No. 877
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau of Vital

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 19 Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2411 Brumback

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
OLAF	V.	HANSON	Nov.	4	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Sept. 13, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lumberman 17	Lumber	Sweden	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-09-1712	Vivian M. Boles	1810 W. Washington Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Uremia	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Chronic Pyelonephritis	3yr
DUE TO (c)	Prostatic Obstruction	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

600X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Apr. 60, to Nov. 4 69, that I last saw the deceased alive on Oct. 23, 1969, and that death occurred at 12:10a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George R Baker MD 019	121 E. Idaho	11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 7, 1969	Cloverdale	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 12, 1969	Myrtle Tolmer	Orville Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4956
Local Reg. No. 813
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Nevada 29
b. COUNTY Humboldt 535
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McDermott
d. STREET ADDRESS (If rural, give location) Orevada Hotel

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Thomas	S.	LanFall	11	4	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	Jan. 27, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Same	Chicago, Ill.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Mrs. J. L. Olsen	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bacteremia 5990	36 hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pneumonia	1 Month
DUE TO (c)	Perirectal abscess	1 Month
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11-2-69	Perineal abscess	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10-8, 1969, to 11-4, 1969, that I last saw the deceased alive on 11-4, 1969 and that death occurred at 6:30 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
395 M.D.		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-8-69	McDermott Cemetery	McDermott, Nevada

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 7 1969	Myrtle Palmer	Erle B. Byram	E-533

FIRM NAME: Erle B. Byram Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4957
Local Reg. No. 857
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn. Home AFB
d. STREET ADDRESS (If rural, give location) 4714-A Adams Place

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ROBERT	LESLIE	FISH	Nov. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Sept. 23, 1954	15				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	High School	Wichita, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert L. Fish	New Jersey	Betty Dowler	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Robert L Fish	Mtn. Home AFB

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 955X Gun Shot Wound To Head

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Apparently Suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Shot self w rifle

22. *I hereby certify that I attended the deceased from* Nov 4, 1969, *to* Nov 5, 19 69 *that I last saw the deceased alive on* Nov 5, 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature]
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 11-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11/7/69
24c. NAME OF CEMETERY OR CREMATORY Winfield, Kansas
24d. LOCATION (City, town, or county) (State) Winfield, Kansas

DATE REC'D BY LOCAL REG. Nov. 25 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

NOV 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 31 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

69-10374 RECEIVED NOV 10 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4958
Local Reg. No. 810
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cambridge
d. STREET ADDRESS (If rural, give location) Box 223

3. NAME OF DECEASED (Type or Print) a. (First) Tammy b. (Middle) Lynne c. (Last) Anderson

4. DATE OF DEATH (Month) (Day) (Year) Nov. 6 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant
8. DATE OF BIRTH Oct. 17 1969
9. AGE (In years last birthday) IF UNDER 1 YR. Months Days 18 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Terry Anderson BIRTHPLACE Burley, Idaho
14. MOTHER'S MAIDEN NAME Arthella Mallory BIRTHPLACE Emmett, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. no
17. INFORMANT'S OWN SIGNATURE X Terry J. Anderson ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Fire maturity

INTERVAL BETWEEN ONSET AND DEATH 18 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/17/69, 19___, *to* 11/6/69, 19___, *that I last saw the deceased alive on* 1 Pm 11/6/69 19___, *and that death occurred at* 7 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE George C. Leichner 558 (Degree or title)
23b. ADDRESS 2181 St Boise
23c. DATE SIGNED 11/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE Nov. 6 1969
24c. NAME OF CEMETERY OR CREMATORY Council, Ida.
24d. LOCATION (City, town, or county) (State) Council Idaho

DATE REC'D BY LOCAL REG. Nov. 6, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Daniel G. Gibson Gibson Funeral Home
LICENSE NO. 400

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4959
Local Reg. No. 818
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 2 months	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002	d. STREET ADDRESS (If rural, give location) 2412 Bella Street

3. NAME OF DECEASED (Type or Print)	a. (First) Alice	b. (Middle) Mae	c. (Last) Corse	4. DATE OF DEATH (Month) (Day) (Year) Nov. 6, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 3, 1890	9. AGE (In years last birthday) 79 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher 12	10b. KIND OF BUSINESS OR INDUSTRY Teacher	11. BIRTHPLACE (State or foreign country) California	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Mead	BIRTHPLACE New York	14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Pennsylvania	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 562-66-8385	17. INFORMANT'S OWN SIGNATURE Mrs. Jay F. Stevens	ADDRESS 2315 Irene St. Boise, Ida.

3940

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Congestive Heart Failure	5 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Mitral Stenosis & Insufficiency	50 yrs
DUE TO (c)	Rheumatic Fever	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 5, 1964, *to* Nov 6, 1969, *that I last saw the deceased alive on* Nov. 5, 1969, *and that death occurred at* 11:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Maurice M. Rubinholdes, M.D. 071 (Degree or title)	23b. ADDRESS 848 La Cassia, Boise	23c. DATE SIGNED 11/10/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE Nov. 10, 1969	24c. NAME OF CEMETERY OR CREMATORY Belmont Memorial Park	24d. LOCATION (City, town, or county) Fresno, (State) California
DATE REC'D BY LOCAL REG. Nov. 12, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Gary A. Cooper	LICENSE NO. E 526

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 2 1969
JAN 1 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

FEB 1 3 1970
APR 2 2 2011

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

State File No. 4960
Local Reg. No. 827
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 011 Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give TOWNSHIP) Boise; c. FACILITY (In this place) DOA	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location) 2112 Amy Avenue

3. NAME OF DECEASED (Type or Print)	a. (First) LINDA	b. (Middle) SUE	c. (Last) FLORY	4. DATE OF DEATH (Month) (Day) (Year) Nov. 6, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Dec. 27, 1968	9. AGE (In years last birthday) IF UNDER 1 YR. Months 10 Days 9 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Anchorage, Alaska	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank C. Flory, BIRTHPLACE San Francisco, Calif.		14. MOTHER'S MAIDEN NAME Teri Scott, BIRTHPLACE Ashland, Oregon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO. None	17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS 2112 Amy Ave. Boise, Idaho		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

466X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) DOA - 5:15 pm 6 NOV 1969

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Marked pulmonary congestion and
DUE TO (c) edema. Acute tracheo-bronchitis.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) Boise (COUNTY) Ada (STATE) Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at ? m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 545 (Degree or title)	23b. ADDRESS 201 E. Bannock	23c. DATE SIGNED 11/14/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-10-69	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Nov. 17 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER [signature]	LICENSE NO. E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
NOV 26 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4961
Local Reg. No. 853
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Montana 27
b. COUNTY: 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lolo
d. STREET ADDRESS (If rural, give location): Rural- Box 193

3. NAME OF DECEASED (Type or Print)
a. (First): Emil
b. (Middle): M
c. (Last): Saltz

4. DATE OF DEATH (Month) (Day) (Year): Nov. 6. 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 4/7/09
9. AGE (In years last birthday): 60
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman 04
10b. KIND OF BUSINESS OR INDUSTRY: Dairy Ranch
11. BIRTHPLACE (State or foreign country): Meadow Grove, Neb.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elmer Saltz
BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Lydia Bennett
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW # 1 3
16. SOCIAL SECURITY NO.: 517-14-8255
17. INFORMANT'S OWN SIGNATURE: Robert Saltz
ADDRESS: Box 155 Vendi Nevada

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8159

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Peritonites

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): acute jejunal perforation
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: occlusion (R) femoral artery
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): auto accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 06
21c. (CITY, TOWN, OR TOWNSHIP) 13080 (COUNTY) (STATE): Banks, Boise, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 5 1969 4:00 a.m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Car hit tree on highway

22. I hereby certify that I attended the deceased from 5 Nov 1969 to 6 Nov 1969 that I last saw the deceased alive on 6 Nov 1969, and that death occurred at 9:52 p.m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] 395 (Degree or title) M.D.
23b. ADDRESS: 403 Idaho Boise, Idaho
23c. DATE SIGNED: 11-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 11/9/69
24c. NAME OF CEMETERY OR CREMATORY: City Cemetery
24d. LOCATION (City, town, or county) (State): Missoula, Montana

DATE REC'D BY LOCAL REG.: Nov. 25 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-527

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Mountain View Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4962
Local Reg. No. 828
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 5125 Overland

3. NAME OF DECEASED (Type or Print): a. (First) JOSEPHINE b. (Middle) MARY c. (Last) DAVIS

4. DATE OF DEATH (Month) (Day) (Year): Nov. 7, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 13, 1890

9. AGE (In years last birthday): 79
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Hermann, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Gatzemeyer
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Mary Kotthoff
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE X Richard E. Davis
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Short

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3/21, 1962, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. 318

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-10-69

24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Cemetery

24d. LOCATION (City, town, or county): Meridian Ada (State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 17 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4963
Local Reg. No. 874
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 12 1969

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 308 Resseguie St.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GEORGE	MARTIN	DONNELLY	Nov. 7 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 6, 1903	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer	Electrical	Beaver Creek, N. C.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles H. Donnelly	Tenn.	Ella Burkett	N. C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-07-2756	Mrs. Elizabeth Donnelly	308 Resseguie Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1962 to Nov 7, 1969, that I last saw the deceased alive on Nov 7 '69, and that death occurred at 11:55 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. Chalmers MD	Boise Idaho	11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 10, 1969	Cloverdale	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 12, 1969	Myrtle Palmer	Robert G. Summers	E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

2 –

NOV 12 1969

AUG 8 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4964
Local Reg. No. 846
Reg. Dist. No. 370

RECEIVED
NOV 26 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Treasure Valley Manor

3. NAME OF DECEASED (Type or Print): a. (First) Lewis b. (Middle) - - - c. (Last) Hartnett

4. DATE OF DEATH: (Month) 11 (Day) 7 (Year) 1969

5. SEX: male

6. COLOR OR RACE: caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: 12/12/1899

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 22

10b. KIND OF BUSINESS OR INDUSTRY: tavern

11. BIRTHPLACE (State or foreign country): Lewisville, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: T.D. Hartnett
BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Jane Bennett
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mrs. George Spence
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

398X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart attack — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Heart attack — 1 mo
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Rheumatic heart disease — 25

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug, 1957, *to* death, 19____, *that I last saw the deceased alive on* 5 Nov, 19 69 *and that death occurred at* 5-30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: C W Blackburn 046 (Degree or title) MD
23b. ADDRESS: Boise, Ida.
23c. DATE SIGNED: 11/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. burial
24b. DATE: 11/10/69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser Washington Idaho

DATE REC'D BY LOCAL REG.: Nov. 24 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Marshall S. Dickerson
LICENSE NO.: E 464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

State File No. 4965
Local Reg. No. 822
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place): 1 Day
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 917 North 7 th.

3. NAME OF DECEASED (Type or Print)	a. (First) Emily	b. (Middle) Anna	c. (Last) Torrance	4. DATE OF DEATH (Month) 11 (Day) 7 (Year) 69	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: Feb, 26 1887	9. AGE (In years last birthday): 82	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse 13	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Samuel Torrance	BIRTHPLACE: Missouri	14. MOTHER'S MAIDEN NAME: Anna Shephard	BIRTHPLACE: St. Louis Missouri		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 561-46-6951	17. INFORMANT'S OWN SIGNATURE: [signature]	ADDRESS: Prearrangement / Boise		

18. CAUSE OF DEATH 4319
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral hemorrhage	15 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral arteriosclerosis	several yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Coronary heart disease	

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-22-69, 19__, *to* 11-7, 19 69, *that I last saw the deceased alive on* 11-7, 19 69, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 3rd Paul F. Miner MD	23b. ADDRESS: 1333 W. Jefferson Boise, Idaho 83702	23c. DATE SIGNED: 11/11/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 11-10-69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho		
DATE REC'D BY LOCAL REG.: Nov. 12, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Erle B. Byram
LICENSE NO.: E-533		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4966
Local Reg. No. 826
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6608 Fairview Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Everett		Conrad	Nov. 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Aug. 13, 1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver 27	Pumice Products	Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward L. Conrad	Missouri	Eliza Whitcomb	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. II +	518-16-5948	Ted Allphin	9625 Halstead Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 5769 Bowel failure; uremia;

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): bronchopneumonia; fatty
DUE TO (c): liver

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Cholecystectomy by Dr. Merrill 11/6/69 cholecystostomy

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10/23/69	small bowel obstruction; P.O. wound dehiscence	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		Boise	Ada	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/21/69, to 11/8/69, *that I last saw the deceased alive on* 11/7/69, *and that death occurred at* 2:50 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard O. Ingalls M.D.	201 E. Bannock	11/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 10, 1969	Dry Creek	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 17 1969	Myrtle Palmer	Gary A. Cowger	E 526

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Summers Funeral Home

NOV 17 1969
FEB 5 1970
OCT 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4967
Local Reg. No. 838
Reg. Dist. No. 370

RECEIVED NOV 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 20 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 816 Clover Dr.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 816 Clover Dr.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Dale	Ransom	Cullison	11/8/69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	7/24/16	53		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Investigator-Ret. '68	General Police	Garnett, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ransom R. Cullison	Indiana	Rosa J. Showalter	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	510-12-7180	Allen Cullison	4420 Clark Circle Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) Had been Ill, had Operation on Legs. — Months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, to __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 1:05 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise.	11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/13/69	Mt'n. View Mem. Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 20 1969	Myrtle Palmer	[signature]	E-527

FIRM NAME: Mountain View Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 15 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

69-10898

BIRTH NO.

RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 4968
Local Reg. No. 847
Reg. Dist. No. 370

NOV 26 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 1 Day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location) 1617 N. 24th St.

3. NAME OF DECEASED (Type or Print) a. (First) BABY BOY KEELE b. (Middle) c. (Last)			4. DATE OF DEATH (Month) Nov. (Day) 8 (Year) 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Nov. 7, 1969	9. AGE (In years last birthday) IF UNDER 1 YR. Months Days 1 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ------ 02	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown	BIRTHPLACE Unknown		14. MOTHER'S MAIDEN NAME Betti Keele	BIRTHPLACE New Mexico
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. -----		17. INFORMANT'S OWN SIGNATURE Betti Keele	ADDRESS 1617 N. 24th Boise, Idaho

486X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	1 Hour
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	aspiration	1 Hour
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cleft Palate + Lip Congenital	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Nov 7, 1969, *to* Nov 8, 1969, *that I last saw the deceased alive on* Nov 8, 1969, *and that death occurred at* 8A *m., from the causes and on the date stated above.*

23a. SIGNATURE 102 B J Cogan	(Degree or title) MD	23b. ADDRESS Boise	23c. DATE SIGNED 11/21/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2	24b. DATE Nov. 11, 1969	24c. NAME OF CEMETERY OR CREMATORY Mtn View Crematory	24d. LOCATION (City, town, or county) Boise Ada (State) Idaho
DATE REC'D BY LOCAL REG. Nov. 24, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER [signature]	LICENSE NO. E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended November 25, 1969

Certificate of Death
STATE OF IDAHO

State File No. 4969
Local Reg. No. 149
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Vets Admin.Hospital,Boise, Ida.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Route #4

3. NAME OF DECEASED (Type or Print): a. (First) Clarence; b. (Middle) B.; c. (Last) Grant
4. DATE OF DEATH: November 9, 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 26, 1890
9. AGE (In years last birthday): 79
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk, Retired
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Medfield,Massachusetts
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Grant — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Mary McDonald — BIRTHPLACE: Nova Scotia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 519-09-6628
17. INFORMANT'S OWN SIGNATURE: James D. Bentley, VA Hospital Records — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

600X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hypostatic Pneumonia & Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
(b) Electrolyte imbalance — 2 days
(c) Convulsive Disorder of CNS — 2 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Emphysema — Unknown

19a. DATE OF OPERATION: Nov 6,1969
19b. MAJOR FINDINGS OF OPERATION: Hypertrophy of Prostate Gland
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 30, 1969 to November 9, 1969, that I last saw the deceased alive on [redacted], and that death occurred at 10:30a.m., from the causes and on the date stated above.

23a. SIGNATURE: Wayne G. Crookston, M.D. 597 (Degree or title)
23b. ADDRESS: VA Center, Boise, Idaho
23c. DATE SIGNED: 11-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-12-69
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: Nov 14,1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Larry S. Kroush
LICENSE NO.: E-447

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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11-20-69

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of CANYON

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Clarence B. Grant (Name on Original Certificate) who died (Was Born or Died) on November 9, 1969 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by Bible Record, Birth Certificate (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 8 Date of birth	May 26, 1892	May 26, 1890
Item 9 Age	77	79

Subscribed and sworn to before me this 22nd day of November, 1969

Notary Public, residing at Notary Public residing at Nampa, Idaho. My Commission expires June 15, 1973.
My commission expires
(Seal)

X Signed Clarence E. Grant
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Rt. #4, Nampa, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of CANYON

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 22nd day of November, 1969

Notary Public, residing at Notary Public residing at Nampa, Idaho. My Commission expires June 15, 1973.
My commission expires
(Seal)

X Signed R W Mesenbrink
(Signature of Any Credible Person)

404- 10th Ave. So, Nampa, Ida.
(Street Address, City, State)

FORM DH 60-155

11-20-69

Clarence B. Grant

Boise, Idaho

November 3, 1969

May 26, 1892
77

May 26, 1890
79

Notary Public residing at

Notary Public residing at

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 17 1969 Bureau of Vital Statistics

State File No. _____
Local Reg. No. 149
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: ADA		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO	b. COUNTY: CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE	LENGTH OF STAY (In this place): 10 DAYS	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN. HOSPITAL, BOISE, IDA.		d. STREET ADDRESS (If rural, give location): ROUTE # 4	

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLARENCE	B.	GRANT	NOVEMBER 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	WIDOWED	MAY 26, 1892	77	--- / ---	--- / ---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CLERK, RETIRED	UNKNOWN	MEDFIELD, MASSACHUSETTS	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
WILLIAM GRANT	OHIO	MARY MC DONALD	NOVA SCOTIA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI	519-09-6628	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Hypostatic Pneumonia & Pulmonary Edema	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. (b)	Electrolyte imbalance	2 days
(c)	Convulsive Disorder of CNS	2 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pulmonary Emphysema	Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov. 6,1969	Hypertrophy of Prostate Gland	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from OCTOBER 30, 19 69, to NOVEMBER 9, 19 69, and that death occurred at 10:30a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
WAYNE G. CROCKSTON, M.D.	VA CENTER, BOISE, IDAHO	11-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/12/69	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 14, 1969	Myrtle Palmer	Jay S. Krouch	E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 1 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4970
Local Reg. No. 877
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 4 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: RESIDENCE 1519 No. 25th, Boise

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1519 No. 25th

3. NAME OF DECEASED (Type or Print): a. (First) Marva b. (Middle) Rydalch c. (Last) Peters

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9th 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 5-7-06

9. AGE (In years last birthday): 63
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oakley, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Davis Hunter Rydalch
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Ester Jane Parkinson
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 564 22 9820

17. INFORMANT'S OWN SIGNATURE: Mae S. Hanks
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4419

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Ruptured Aorta Massive Bleeding. Mins; Mouth & Nose.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Not Determined.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did Not See Alive *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise
23c. DATE SIGNED: 11-26-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-24-69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 3 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

MAY 1 1970
AUG 9 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4971
Local Reg. No. 87
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) E. 6th & Hanthorn

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ELDON	W.	WALKER	Nov.	9	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Oct. 3, 1900	69	1	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher
10b. KIND OF BUSINESS OR INDUSTRY Livestock
11. BIRTHPLACE (State or foreign country) Weiser, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Walker — BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Jennie Ashley — BIRTHPLACE Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-32-2983
17. INFORMANT'S OWN SIGNATURE x Robert H. Walker — ADDRESS Weiser

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1888 Carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH 6 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 7-26-65
19b. MAJOR FINDINGS OF OPERATION Cancer of bladder
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 14, 1965, *to* Nov 9, 1969 *that I last saw the deceased alive on* Nov 18, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE T B Jeppesen (Degree or title) M D
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 11-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Nov. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 1 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER L. Lee Thomason
LICENSE NO. E-388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4972
Local Reg. No. 836
Reg. Dist. No. 370

RECEIVED NOV 20 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Boise
c. LENGTH OF STAY (In this place) Years.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 4717 Gage St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
J.	Lealand	Crawforth	11 - 10 - 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Aug. 24, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mechanic 21	same	Spring City, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James M. Crawforth	Utah	Anna Nielson	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-07-4240A	Evelyn D Crawforth	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis - Atheroma's

DUE TO (c) Bronchopneumonia

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's disease

4339

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1965, 19__, to Nov. 10, 1969, that I last saw the deceased alive on Nov. 10, 1969, and that death occurred at 10:__ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert M. Dwyer, M.D.	Boise, Idaho	11.17.69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	11-14-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 20 1969	Myrtle Palmer	[illegible]	E-366

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 2 0 1969

APR 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4973
Local Reg. No. 820
Reg. Dist. No. 370

BIRTH NO.

RECEIVED

NOV 13 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 1503 N. 17th St.

3. NAME OF DECEASED (Type or Print) a. (First): Joseph	b. (Middle): Manville	c. (Last): Downs	4. DATE OF DEATH (Month) (Day) (Year): Nov. 10, 1969		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Feb. 7, 1890	9. AGE (In years last birthday): 79	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician 14	10b. KIND OF BUSINESS OR INDUSTRY: Medicine	11. BIRTHPLACE (State or foreign country): Chicago, Illinois	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Charles Manville Downs	BIRTHPLACE: New Haven, Conn.	14. MOTHER'S MAIDEN NAME: Caroline Greeves	BIRTHPLACE: Patterson, N.J		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I 3	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: X Mrs. J. M. Downs	ADDRESS		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Ascending spina cord paralysis	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Metastatic carcinoma	
DUE TO (c)	Adenocarcinoma Prostate	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Bleeding diverticulosis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 3 - 2, 1968, *to* 11 - 10, 1969, *that I last saw the deceased alive on* 11 - 10, 1969, *and that death occurred at* 9a *m., from the causes and on the date stated above.*

23a. SIGNATURE: Everett W. Jones Jr. 267 (Degree or title) MD	23b. ADDRESS: Boise -	23c. DATE SIGNED: 11/12/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 11/12/1969	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cem.	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Nov. 13, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Paul Waggoner	LICENSE NO.: E-422

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

NOV 18 1969

DEC 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 24 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended Nov. 20, 1969

Certificate of Death
STATE OF IDAHO

State File No. 4974
Local Reg. No. 835
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1809 N. 31st

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1809 N. 31st Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lillian	W.	Seyfert	November 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	July 23, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher 12	Public Schools	Strong City, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Everett Wilson	Kansas	Effie Thomas	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-34-9855	Edith S. Kinucan	1809 N. 31st, Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic Ca to Liver

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchialgenic Carcinoma
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-13, 1969, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald M. Mack, M.D. 318	Orchard St., Boise	11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	11-10-69	Mountain View	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 20, 1969	Myrtle Palmer	Andrew P. Dembrowski Not embalmed	#527

FIRM NAME: Mountain View Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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11-20-69

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss. RECEIVED Certificate No. .....

County of ..... } NOV 20 1969 Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)

for Lillian Seyfert (Name on Original Certificate) Bureau of Vital Statistics who died (Was Born or Died) on Nov. 10, 1969 (Date of Event)

in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 8 Date of birth	July 23, 1898	July 23, 1897
Item 14	Thomsa	Thomas

Subscribed and sworn to before me this 21st day of November, 1969

Genevieve Creswell

Notary Public, residing at Boise

My commission expires Sept 10, 1970

(Seal)

Signed [signature]

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

P.O. Box 7217 Boise

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.

County of Ada }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 21st day of November, 1969

Genevieve Creswell

Notary Public, residing at Boise

My commission expires Sept 10, 1970

(Seal)

Signed [signature]

(Signature of Any Credible Person)

1205 Bannock St. Boise, Idaho

(Street Address, City, State)

FORM DH 60-155

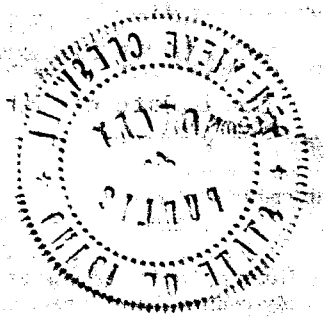
NOTARY
PUBLIC
STATE OF IDAHO

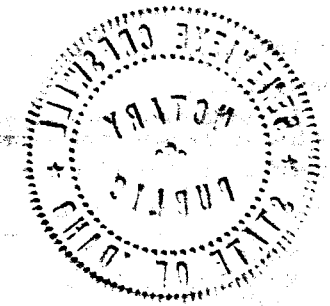
NOTARY
PUBLIC
STATE OF IDAHO

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 835
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 20 1969

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1809 N. 31st.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1809 N. 31. st. Street

3. NAME OF DECEASED (Type or Print): a. (First) Lillian b. (Middle) W. c. (Last) Seyfert

4. DATE OF DEATH (Month) (Day) (Year): 11/10/69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	7/23/98	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher	Public Schools	Strong City, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Everett Wilson	Kansas	Effie Thomsa	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-34-9855	Edith S. Kinnear	1809 N. 31 Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic CA to Liver

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Bronchial Genic Carcinoma

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/13, 1969, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Orchard St. Boise	11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	11/10/69	Mountain View	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 20 1969	Myrtle Palmer	Not embalmed	E-527

FIRM NAME: Mountain View Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 21 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4975
Local Reg. No. 829
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION: Restful Manor 393

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 419 South 5th

3. NAME OF DECEASED (Type or Print): a. (First) Manuel; b. (Middle); c. (Last) Aberasturi

4. DATE OF DEATH: (Month) 11; (Day) 11; (Year) 69

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 10-31-1883

9. AGE (In years last birthday): 86

IF UNDER 1 YR. Months; Days

IF UNDER 24 HRS. Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Various Jobs 04

10b. KIND OF BUSINESS OR INDUSTRY: Sheep Ranching

11. BIRTHPLACE (State or foreign country): Artiaga, Sapin

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Manuel Aberasturi
BIRTHPLACE: Spain

14. MOTHER'S MAIDEN NAME: Unkhown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-09-8410

17. INFORMANT'S OWN SIGNATURE: X Julia Vasquez
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4409

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hemopneumothorax

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture of Ribs

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR 27, 19 69, to NOV 11, 19 69, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE: Bruce Moody 368 (Degree or title) MD

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-14-69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Erle B. Byrd E. B. Byrd

LICENSE NO.: E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

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IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4976
Local Reg. No. 830
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION: At Home 2512 Redway Dr. 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2512 Redway Drive

3. NAME OF DECEASED (Type or Print): a. (First) RUTH; b. (Middle) M.; c. (Last) CARLSON

4. DATE OF DEATH: (Month) Nov. (Day) 11 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Apr. 21, 1916

9. AGE (In years last birthday): 53
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Whitetail, Montana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Sleep
BIRTHPLACE: Wisconsin

14. MOTHER'S MAIDEN NAME: Lena Kruschbaum
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-09-5460

17. INFORMANT'S OWN SIGNATURE: Mel R Carlson
ADDRESS: 2512 Redway Dr. Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 955X Self Inflicted Gun Shot Thru Forehead. — Inst;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Despondency. takeing Psychiatry Treatments. — Months.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No. X

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 2 Suicide
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 31
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 130 11
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not to See Alive, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 10A m., *from the causes and on the date stated above.*

23a. SIGNATURE: 553 E. Farris (Degree or title): Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: II-14-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county): Moscow
(State): Latah Idaho

DATE REC'D BY LOCAL REG.: Nov. 17 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Robert G. Summers
LICENSE NO.: E-497
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 15 1969
DEC 18 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4977
Local Reg. No. 848
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): few min.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002	d. STREET ADDRESS (If rural, give location): 1830 Bedford Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Julius	Eugene	Elliott, Jr.	Nov. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Dec. 17, 1960	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	Grade School	Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Julius E. Elliott	Mississippi	Lynda A. Chandler	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE
No	None	None	1830 Bedford Boise x Julius E. Elliott

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive Brain Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Contusion & skull fract. — 1 hr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	CO	13011

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
II II 69 12P m.		With other boys, Playing on large Beam, it fell. Hit boy on head.

22. *I hereby certify that I attended the deceased from* Did Not See Alive *on* 11-11-69, 19__, *and that death occurred at* 1 P m., *from the causes and on the date stated above.* 19__, *that I last saw the deceased alive* Coroner.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. B. Gattiker 412 M.D.	1203 Broadway, Boise, Ida.	11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Nov. 13, 1969	Center Hill	Paragould, Arkansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 24, 1969	Myrtle Palmer	Harry A. Summers	E 526

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JUL 19 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4978
Local Reg. No. 840
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002	d. STREET ADDRESS (If rural, give location) 3207 Edgemoor

3. NAME OF DECEASED (Type or Print) a. (First) SHANE b. (Middle) ALLEN c. (Last) WATSON				4. DATE OF DEATH (Month) (Day) (Year) November 11, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant	8. DATE OF BIRTH 11-10-69	9. AGE (In years last birthday) one day	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 02		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Ramon Dean Watson		BIRTHPLACE Boise, Idaho	14. MOTHER'S MAIDEN NAME Eugenia Ray	BIRTHPLACE Boise, Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 00	(If yes, give war or dates of service) 00	16. SOCIAL SECURITY NO. 00	17. INFORMANT'S OWN SIGNATURE X Ramon D Watson	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5512

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Intestinal Evisceration	1 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Intrauterine rupture of	4
DUE TO (c)	omphalocoele	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 11-10-69	19b. MAJOR FINDINGS OF OPERATION as above	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-10, 1969, *to* 11-11, 1969, *that I last saw the deceased alive on* 11-11, 1969, *and that death occurred at* P *m., from the causes and on the date stated above.*

23a. SIGNATURE Fay T Dunstant 519 (Degree or title)	23b. ADDRESS 200 E Bannock Boise	23c. DATE SIGNED 11-14-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-15-69	24c. NAME OF CEMETERY OR CREMATORY Dry Creek	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Nov. 21, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Conway Grant	LICENSE NO. 478E

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4979
Local Reg. No. 858
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 26 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 023

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 440
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print)
a. (First): NEIL
b. (Middle): BRIAN
c. (Last): BUNKER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 12 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: August 7, 1955
9. AGE (In years last birthday): 14 — IF UNDER 1 YEAR: Months 3, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Student
11. BIRTHPLACE (State or foreign country): Rawlins, Wyoming
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Neil T. Bunker — BIRTHPLACE: Delta, Utah
14. MOTHER'S MAIDEN NAME: Mary E. Ingram — BIRTHPLACE: Clinton, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Melvin J. Stippich — ADDRESS: Cambridge

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

9229

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gun Shot Wound to Head

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 31
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13000
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-11-69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Accidentally Shot

22. *I hereby certify that I attended the deceased from* 11-11, 1969 *to* 11-12, 1969, *that I last saw the deceased alive on* 11-12, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 704
23b. ADDRESS
23c. DATE SIGNED: 11-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salubria Cemetery
24d. LOCATION (City, town, or county) (State): Cambridge Idaho

DATE REC'D BY LOCAL REG.: Nov. 25, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: R. Dale Thomason
LICENSE NO.: E-388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
RECEIVED STATE OF IDAHO

State File No. 4980
Local Reg. No. 831
Reg. Dist. No. 370

BIRTH NO.

NOV 20 1969

Bureau of Vital Stat.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Stockdale~~ Boise	c. LENGTH OF STAY (In this place): 2 weeks
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print)	a. (First): CHARLES	b. (Middle): PETER	c. (Last): DeMOND	4. DATE OF DEATH (Month) (Day) (Year): Nov. 12, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married	8. DATE OF BIRTH: July 29, 1898	9. AGE (In years last birthday): 71 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Castle Gate, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William DeMond	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Hermine Schrey	BIRTHPLACE: Germany	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-44-8569	17. INFORMANT'S OWN SIGNATURE: X Wm F. Demond	ADDRESS: R2 Boise Id.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1519 Carcinoma of the Stomach. — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1967, 19__, *to* Nov., 1969, *that I last saw the deceased alive on* 11-12-, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title)	23b. ADDRESS: 125 E. Idaho	23c. DATE SIGNED: 11/17/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 11/15/69	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park	24d. LOCATION (City, town, or county): Boise, (State): Idaho
DATE REC'D BY LOCAL REG.: Nov. 17 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: G. W. Waters [signature]	LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 23 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 4981
Local Reg. No. 841
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 01 NOV 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1 week

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE California 05 b. COUNTY Los Angeles 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Los Angeles

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Alphonsus Hospital 003
d. STREET ADDRESS (If rural, give location) 3278 Wilshire Blvd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Marie	Davis	Fletcher	11	12	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	April 17 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife 01	Same	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert K. Davis	Medford, Oregon	Christina May Davis	Placerville

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	Unknown	Robert Fletcher	Los Angeles, Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adrenocortical insufficiency
DUE TO (c) Rheumatoid arthritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug , 1969, *to* 11/6 , 1969, *that I last saw the deceased alive on* , 19 *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-17-69	Holy Cross Cemetery	Los Angeles, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21, 1969	Myrtle Palmer	Erle B. Bynum	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

NOV 24 1969

Bureau of Vital Statistics

State File No. 4982
Local Reg. No. 839
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 6days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 14 S. Orchard

3. NAME OF DECEASED (Type or Print) a. (First) Pauline b. (Middle) V. c. (Last) Hilton

4. DATE OF DEATH (Month) (Day) (Year) 11/12/69

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Oct. 11, 1897

9. AGE (In years last birthday) 72
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (State or foreign country) Washington, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Eddie A. Vincent
BIRTHPLACE unk.

14. MOTHER'S MAIDEN NAME Nellie L. Smith
BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 521 10 5043

17. INFORMANT'S OWN SIGNATURE Janet A. Bowman
ADDRESS 504 Franklin Dr. Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Middle Cerebral Artery hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive Cardio Vascular Disease — 4y3

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-6, 1969, *to* 11-12, 1969, *that I last saw the deceased alive on* 11-11, 1969, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS 125 E. Idaho

23c. DATE SIGNED 11/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment

24b. DATE 11/14/69

24c. NAME OF CEMETERY OR CREMATORY Mountain View Mausoleum

24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 20, 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER

LICENSE NO. E-527

FIRM NAME Mountain View Funeral Home, Boi

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

4 copies Total (002

Certificate of Death
STATE OF IDAHO

State File No. 4983
Local Reg. No. 825
Reg. Dist. No. 270

BIRTH NO.

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1429 Euclid Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Gladys	Emma	McManimie	Nov. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Never Married	Dec. 16, 1910	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.S. Air Force 05	Retired Major	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Burton A. McManimie	Missouri	Louella Burkhard	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW 2 & Korea 6	519-07-9875	X Ruth A. Family	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) MASSIVE INTRACEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 10 HRS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Unknown.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from NOV 12 1969, to _____, 19____, that I last saw the deceased alive on NOV 12 1969, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. C. Johnson	M.D.	Boise Idaho	11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/15/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 17 1969	Myrtle Palmer	Lloyd Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 17 1969

NOV 20 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4984
Local Reg. No. 155
Reg. Dist. No. 271

BIRTH NO.

RECEIVED
DEC 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5325 Bloom Street 040

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 5325 Bloom Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
VINA	JARRETT	WRIGHT	11	12	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	May 5, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerical Work 05	Government	Nova Scotia	USA

Ada County

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
no record		no record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519 36 2173	X Robert E Baker	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Apparently Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Unknown. No Injuries.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19, *that I last saw the deceased alive on* [illegible] *and that death occurred at* 1CP *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] 533 4 (Degree or title) Coroner	3720 Meadow Drive, Boise.	11-21-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 17, 1969	Syringa Gardens	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 28, 1969	Myrtle Palmer	Andrew P. Pavlovske	E-527

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DR-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4985
Local Reg. No. 849
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate, (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1300 Vermont Ave

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Emma		Yost	11	12	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Feb. 12, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Same	Culbertson Nebr.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Brehn	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-34-3792A	Frances Yost	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4379 Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12/7, 1969, *to* 11/12, 1969, *that I last saw the deceased alive on* 11/12, 1969, *and that death occurred at* 7 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] M.D.	[illegible]	11/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-15-69	Terrace Lawn Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 24, 1969	Myrtle Palmer	Erle B. Byram	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4986
Local Reg. No. 837
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 7323 Swift Lane

3. NAME OF DECEASED (Type or Print): a. (First) Ray; b. (Middle) W.; Epler

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 13, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 12, 1887

9. AGE (In years last birthday): 82
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto repairman 31

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Pittsburg, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Epler
BIRTHPLACE: Ill.

14. MOTHER'S MAIDEN NAME: Mary Bowler
BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 563-46-0850

17. INFORMANT'S OWN SIGNATURE: Ruth R Epler
ADDRESS: Donnelly, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — —
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* February 7, 1969, *to* Nov 13, 1969, *that I last saw the deceased alive on* November 12, 1969, *and that death occurred at* 4:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. L. Imbler, M.D.

23b. ADDRESS: 6613 Ustick Rd, Boise, Idaho

23c. DATE SIGNED: 11/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-17-69

24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery

24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Nov. 20, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Geo. Penrod

LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
BIRTH NOV 21 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4987
Local Reg. No. 833
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 10 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 402 East 41st Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THOMAS	ALLEN	GORDON	Nov. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 17, 1872	97		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	same	Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Gordon			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-22-6717	Hattie J. Gordon	402 E. 41st Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

"This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Parkinsonism

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 30 1969 *to* Nov 13 1969 *, that I last saw the deceased alive on* Nov 12 1969 *, and that death occurred at* 1:45 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 333	808 La Cassia Dr. Boise	11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-14-69	Joplin Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 19 1969	Myrtle Palmer	Robert G. Lord	E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4988
Local Reg. No. 634
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 21 1969 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 01

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY IN THIS PLACE (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Washington 44

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge

d. STREET ADDRESS (If rural, give location): rural Valley View area

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Blanche	Anne	Wilkerson	11	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	married	6/22/1890	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Eureka Springs, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Uriah Shroyer	--	Martha Joslin	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		A. D. Wilkerson	Cambridge, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Degeneration — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug, 1963, *to* Nov, 1969, *that I last saw the deceased alive on* Nov 2, 1969, *and that death occurred at* 330 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. C. Johnson 361	MD	Boise Idaho	11/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
rem. burial	11/17/69	Salubria Cemetery	Cambridge Washington Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 19 1969	Myrtle Palmer	A. Dale Thomas	E 388

FIRM NAME Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 12 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 26 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4989
Local Reg. No. 850
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1418 West State Street

3. NAME OF DECEASED (Type or Print)
a. (First) MURRAY
b. (Middle) D.
c. (Last) BADGLEY

4. DATE OF DEATH (Month) (Day) (Year) Nov. 16, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 23, 1883
9. AGE (In years last birthday) 85
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 08
Engineer - U. S. Public Survey
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Peughkeepsie, N. Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE Charles Badgley-Peughkeepsie, N.Y.
14. MOTHER'S MAIDEN NAME BIRTHPLACE Fannie Murray-Delaware Co., N.Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 519-24-4693
17. INFORMANT'S OWN SIGNATURE ADDRESS 1418 State St. Genevra E. Badgley Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart attack. — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease — 10 yrs
DUE TO (c) with heart block.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1958, *to* death, 19____, *that I last saw the deceased alive on* Nov 3, 1969, *and that death occurred at* 1:50 AM *from the causes and on the date stated above.*

23a. SIGNATURE 046 [signature] (Degree or title) MD
23b. ADDRESS 800 La Cassia Dr Boise
23c. DATE SIGNED 20 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-18-69
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. Nov. 24 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-509

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 26 1969
DEC 18 1969
NOV 13 1970
JAN 7 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

State File No. 4990
Local Reg. No. 843
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise LENGTH OF STAY (In this place) 1 Day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location) 1021 Vermont Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) JOSEPH	b. (Middle) LEONARD	c. (Last) BROGDON	4. DATE OF DEATH (Month) Nov. (Day) 16 (Year) 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 14, 1902	9. AGE (In years last birthday) 67 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman 11	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Marshall, Texas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Orvid Brogdon	BIRTHPLACE Louisiana	14. MOTHER'S MAIDEN NAME Sudie Scott	BIRTHPLACE Louisiana	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-09-2431A	17. INFORMANT'S OWN SIGNATURE Mrs Erma S. Brogdon	ADDRESS 1021 Vermont Boise, Idah	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic Bronchogenic Ca — INTERVAL BETWEEN ONSET AND DEATH 2 < 1y

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1-, 1969, *to* 11-16, 1969, *that I last saw the deceased alive on* 11-16, 1969, *and that death occurred at* 6:25a *m., from the causes and on the date stated above.*

23a. SIGNATURE Wm D Forney 173 (Degree or title) MD	23b. ADDRESS 485 Bannock Boise	23c. DATE SIGNED 11-16-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 19, 1969	24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens	24d. LOCATION (City, town, or county) Boise Ada (State) Idaho
DATE REC'D BY LOCAL REG. Nov. 24, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Norwell Delmaray	LICENSE NO. E-509

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

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NOV 25 1969

DEC 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
NOV 26 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4991
Local Reg. No. 851
Reg. Dist. No. 570

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 912 Franklin Street

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) L. c. (Last) Chapman
4. DATE OF DEATH (Month) (Day) (Year): Nov. 16, 1969
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 13, 1882
9. AGE (In years last birthday): 87
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Miami, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Augustine Leftwich
BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Jenny Waters
BIRTHPLACE: St. Louis, Mo.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-34-0930
17. INFORMANT'S OWN SIGNATURE: x Irene C Booton
ADDRESS: 1310 Franklin Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease — (?) yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 13, 1969, to Nov. 16, 1969, that I last saw the deceased alive on Nov. 16, 1969, and that death occurred at 2:15 PM, from the causes and on the date stated above.

23a. SIGNATURE: Paul F. Miner 364 MD (Degree or title)
23b. ADDRESS: 1333 W. Jefferson Boise, Idaho 83702
23c. DATE SIGNED: 11/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-19-69
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Nov 24 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Lowell W. Summers
LICENSE NO.: E-509
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4992
Local Reg. No. 878
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 3 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 023	d. STREET ADDRESS (If rural, give location): 1904 Kerr Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)	
AROET	(ROE)	HERRICK	Nov. 16, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Dec. 16, 1889	9. AGE (In years last birthday): 79 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: Farmer	11. BIRTHPLACE (State or foreign country): Warren, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Wm. James Herrick	BIRTHPLACE: Ogden, Utah	14. MOTHER'S MAIDEN NAME: Emma Jane Wright	BIRTHPLACE: Philadelphia, Penna.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):	16. SOCIAL SECURITY NO.: 529-26-5408	17. INFORMANT'S OWN SIGNATURE: Eva Bartel	ADDRESS: Boise, Idaho	

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Edema

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease
DUE TO (c) Arteriosclerotic Cardiovascular Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* Nov, 19 69, *that I last saw the deceased alive on* 16 Nov, 19 69, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Lawrence Merrill 357 (Degree or title)	23b. ADDRESS: Boise Ida	23c. DATE SIGNED: 12-1-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal	24b. DATE: 11-20-69	24c. NAME OF CEMETERY OR CREMATORY: Afton Cemetery	24d. LOCATION (City, town, or county) (State): Afton, Wyoming
DATE REC'D BY LOCAL REG.: Dec. 3, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Conway Grant	LICENSE NO.: E-478

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 18 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4993
Local Reg. No. 150
Reg. Dist. No. 371

RECEIVED NOV 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
LENGTH OF STAY (in this place): Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5921 Wright Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Filer,
d. STREET ADDRESS (If rural, give location): Rural Route Filer, Idaho

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Fred	L.	Holloway	11 - 16 - 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	7 - 19 - 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor 04	Farming	Seiling, Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
T.F. Holloway	Marion County, Ka.	Olie Thomas	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. # 2	519-30-3201 A	Kathryn Hawkins	Twin Falls, Idaho

4709

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis, — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Heart Treatments by Physican. Alsc, Dropsey. — Weeks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19__, *that I last saw the deceased alive on* ____ 19__, *and that death occurred at* 430A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Coroner	3720 Meadow Drive, Boise.	11-17-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-19-1969	Filer I.O.O.F. Cemetery	Filer, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21, 1969	Myrtle Palmer	[signature]	E-527

FIRM NAME: Mountain View Funeral Home,

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 26 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4994
Local Reg. No. 852
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 1½ Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 808 North Curtis Road

3. NAME OF DECEASED (Type or Print)
a. (First) THOMAS
b. (Middle) JEFFERSON
c. (Last) PAYNE

4. DATE OF DEATH (Month) (Day) (Year) Nov. 17, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Sept. 10, 1880
9. AGE (In years last birthday) 89
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Same
11. BIRTHPLACE (State or foreign country) Oreana, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unkown
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 518-38-0911
17. INFORMANT'S OWN SIGNATURE County Welfare Record
ADDRESS [signature] - 1205 Bannock St. Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 6, 1969, *to* Nov 17, 1969, *that I last saw the deceased alive on* Nov 17, 1969, *and that death occurred at* 5:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 333 (Degree or title)
23b. ADDRESS 808 La Cassia Dr Boise
23c. DATE SIGNED 11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-20-69
24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. Nov. 24, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
DEC 8 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4995
Local Reg. No. 581
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 213 S. 9th. Street 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Star
d. STREET ADDRESS (If rural, give location): Rural Roure # 1

3. NAME OF DECEASED (Type or Print): a. (First) Peggy; b. (Middle) L; c. (Last) Spring

4. DATE OF DEATH: (Month) (Day) (Year): November 13, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: July 18, 1937

9. AGE (In years last birthday): 32 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress 06

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Mancos, Colorado

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Felix J. Tackitt — BIRTHPLACE: Texas

14. MOTHER'S MAIDEN NAME: Zula Nichols — BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 519-38-7543

17. INFORMANT'S OWN SIGNATURE: Zula Tackitt — Rt. 1 ADDRESS: Star, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Portal Chrosis of the Liver. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Inebriation Convulsion. — Mins;
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 10P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] — (Degree or title): Coroner

23b. ADDRESS: 3720 Meadow Drive, Boise,

23c. DATE SIGNED: 11-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/22/69

24c. NAME OF CEMETERY OR CREMATORY: Star Cemetery

24d. LOCATION (City, town, or county) (State): Star, Idaho

DATE REC'D BY LOCAL REG.: Dec 4, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature] — LICENSE NO.: E-527

FIRM NAME: Mountain View Funeral Home, Bois

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 4996
Local Reg. No. 153
Reg. Dist. No. 371

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA (011)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 12 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA (011)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 423 SOUTH 12TH STREET

3. NAME OF DECEASED (Type or Print): a. (First) WALTER; b. (Middle) RUSSELL; c. (Last) HARRIS

4. DATE OF DEATH (Month) (Day) (Year): NOVEMBER 18, 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 9-15-1896

9. AGE (In years last birthday): 73
IF UNDER 1 YR. Months ___ Days ___
IF UNDER 24 HRS. Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BRICKLAYER

10b. KIND OF BUSINESS OR INDUSTRY: BUILDING

11. BIRTHPLACE (State or foreign country): ARGABENNY, WALES

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ALBERT V. HARRIS
BIRTHPLACE: ENGLAND

14. MOTHER'S MAIDEN NAME: EMILY RIDGEWAY
BIRTHPLACE: ENGLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WWII 4

16. SOCIAL SECURITY NO.: 518-01 3551

17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pneumonia, aspiration — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cholecystitis, acute — 12 days
DUE TO (c): Peritoneal abscess, localized — 10 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from NOVEMBER 6, 19 69, to NOVEMBER 18, 19 69, and that death occurred at 5:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE: J.K. HELFERTY, M.D. 597 (Degree or title)

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-22-69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Nov. 25 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]

LICENSE NO.: E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

NOV 28 1969

Bureau of Vital Statistics

State File No. 4997
Local Reg. No. 154
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3512 N. Maple Grove Rd. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3512 N. Maple Grove Rd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lydia	Anne	Kading	Nov. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Jan. 17, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Grangeville, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Aaron F. Parker	England	Mary Scott Newman	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-12-7056		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — 20 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 10, 1965, to Nov. 18, 1969, *that I last saw the deceased alive on* Sept 14, 1969, *and that death occurred at* 1:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles R. Morgan	370 M.D	Boise, Idaho	24 Nov 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/21/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 26, 1969	Myrtle Palmer	Earl Waggoner	E-422

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

JUN 23 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4998
Local Reg. No. 861
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5036 Bel Air

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 5036 Bel Air

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Darlene	Dunaway	Talbot	Nov.	18,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	July 7, 1916	53		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Christian Science Practitioner		Vale, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. P. Dunaway	Whitewright, Tex.	Rosella Houston	Woodland, Tex.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-07-1374	Mardon F Talbot	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4272

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Probable blockage of bowel

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from AS CORONER ONLY to DID NOT SEE ALIVE that I last saw the deceased alive on _____, 19____, and that death occurred at 7:45a m. from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 583	Coroner	3720 Meadow Dr., Boise	11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	11/21/1969	Mtn. View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 26, 1969	Myrtle Palmer	A. E. Alden	299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 30 1970

JAN 31 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4999
Local Reg. No. 862
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 28 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada County 011
b. CITY OR TOWN Boise
LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Alphonses Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN Boise
d. STREET ADDRESS 3009 Virginia Ave (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Edwin b. (Middle) C. c. (Last) Ward

4. DATE OF DEATH (Month) (Day) (Year): Nov 18 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 29 1884

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lincoln Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Ward
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Mary Lansing
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO. 542 24 8685 A

17. INFORMANT'S OWN SIGNATURE: Mrs Elizabeth Berg ADDRESS 3007 Virginia Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4989

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auricular Flutter — 4 Days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* AUGUST, 1968, to NOV, 1969, *that I last saw the deceased alive on* 11-18, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. B. Sullivan M2 (Degree or title) MD
23b. ADDRESS: 1203 BROADWAY Boise IDA
23c. DATE SIGNED: 11-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov 19 1969
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: Nov. 26, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden
LICENSE NO.: E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 2 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUN 23 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or rural number refers to PLACE WHERE DEATH OCCURRED. In deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 5000
Local Reg. No. 151
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA — NOV 2 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION: V.A.HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 240
a. STATE: IDAHO
b. COUNTY: GOODING
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WENDELL
d. STREET ADDRESS (If rural, give location): 461 AVENUE A EAST

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LOREN	C.	BIRD	NOV. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	DIVORCED	NOV.29,1923	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SHEEPHERDER 04	SAME	JEROME, IDAHO	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNK.	UNK.	MYRL MILLSAP	UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWII 4		[signature]	V.A.HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2509

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Diabetes mellitus	not known
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cirrhosis of the liver	not known
DUE TO (c)	Terminal bronchopneumonia	2 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from Nov. 18, 1969, to Nov. 19, 1969, and that death occurred at 4:25A m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Rimel O. RIML, M.D. (Degree or title) [redacted], M.D. 590	V. A. HOSPITAL, BOISE, IDAHO	11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-22-69	Wendell Cemetery	Wendell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21, 1969	Myrtle Palmer	Earle Gibson	E533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5001
Local Reg. No. 865
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: 220 E. Gettysburg

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 220 E. Gettysburg

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ARTHUR	EINAR	GARNESS	Nov. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Dec. 15, 1907	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Turnkey 08	Ida. State Prison	Ada, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nels Garness	Norway	Johanna Gjerde	Bergen, Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-03-3049	Mrs. Helen M. Garness	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Upper Respiratory Inf — 1 wk
DUE TO (c) Complete Thoracoplasty Rt — 20 yrs?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Old Healed TB Rt Lung — 20 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3-25 — 1958, *to* 11-19, 1969, *that I last saw the deceased alive on* Nov. 19, 1969, *and that death occurred at* 1:30 AM *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl B. Knutson	MD	Boise Idaho	11-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/22/1969	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 26, 1969	Myrtle Palmer	Earl Waggoner	E-422

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 5002
Local Reg. No. 842
Reg. Dist. No. 270

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011 — NOV 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 15 years
d. FULL NAME OF HOSPITAL OR INSTITUTION 517 Sierra Dr. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 517 Sierra Dr.

3. NAME OF DECEASED (Type or Print) a. (First) Jill b. (Middle) Marie c. (Last) Pagoaga
4. DATE OF DEATH (Month) (Day) (Year) November 19 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	never married	Oct. 25, 1954	15		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 00		Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard J. Pagoaga	Boise, Idaho	Kathreen E. Wilson	Weiser, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	x R. J. Pagoaga	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — 2381

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Brain tumor

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-15-59, 19__, *to* 9/19, 19 67, *that I last saw the deceased alive on* 11-5-69, 19 67, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] MD		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 21, 1969	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21 1969	Myrtle Palmer	Merle Byram	E533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5003
Local Reg. No. 152
Reg. Dist. No. 371

BIRTH NO.

RECEIVED NOV 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 7 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO
b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 1501 WEST FORT STREET

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEWIS	C.	SCOTT	NOVEMBER 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	MARCH 6, 1884	85	--- / ---	--- / ---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MILITARY SERVICE 05	U.S. ARMY	QUINCY, KENTUCKY	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOSEPH SCOTT	KENTUCKY	JENNIE SMITH	KENTUCKY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	SAW	518-18-7976 A	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

485X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia, terminal.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Tumor, type undetermined.
a. Mediastium.
b. Ascending colon.

INTERVAL BETWEEN ONSET AND DEATH: 3 Yrs. 1 month

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from NOVEMBER 12, 1969, to NOVEMBER 19, 1969, and that death occurred at 6:05 am from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D. 597		VA CENTER, BOISE, IDAHO	11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	11-21-69	Morris Hill	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 25, 1969	Myrtle Palmer	Conway Grant	E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

8 -

NOV 25 1969
SEP 16 1991

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
DEC 3 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5004
Local Reg. No. 868
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 14 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 610 South 15th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NELLIE	B.	BUTLER	Nov. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Feb. 19, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Bazile Mills, Neb.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Clements	Iowa	Emmline Lewman	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	530-12-6755	Newton A. Butler	Boise, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Hepatic failure	1 wk
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Carcinoma Bile duct	1+ year.
DUE TO (c)	—	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Congestive Heart failure	—

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from March, 1969, to Nov. 20, 1969, that I last saw the deceased alive on Nov. 19, 1969 and that death occurred at 8:00 AM from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Draper	M.D.	Boise Idaho	Nov. 24, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-24-69	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Myrtle Palmer	Robert G. Ross	E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 21 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5005
Local Reg. No. 844
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 2060 Wildwood St.

3. NAME OF DECEASED (Type or Print)	a. (First): Peder	b. (Middle): A.	c. (Last): Paulson	4. DATE OF DEATH (Month) (Day) (Year): Nov. 20, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Sept. 12, 1897	9. AGE (In years last birthday): 72 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 09	10b. KIND OF BUSINESS OR INDUSTRY: Power	11. BIRTHPLACE (State or foreign country): Tennskjer, Norway	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Paul Jacobsen	BIRTHPLACE: Norway	14. MOTHER'S MAIDEN NAME: Kristine Pederson	BIRTHPLACE: Norway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-07-2746	17. INFORMANT'S OWN SIGNATURE: X Mrs. Evelyn Paulson	ADDRESS:	

5699

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Bowel necrosis.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/25, 1969, *to* 11/20, 1969, *that I last saw the deceased alive on* 11/20, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 045 (Degree or title): M.D.	23b. ADDRESS: Boise, Ida	23c. DATE SIGNED: 11/25/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 11-22-69	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park	24d. LOCATION (City, town, or county): Boise, (State): Idaho
DATE REC'D BY LOCAL REG.: Nov. 25 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Clyde J. Vassar [signature]	LICENSE NO.: E-535

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 5 1960

DEC 8 1969

MAR 2 5 1970

JUL 1 6 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5006
Local Reg. No. 866
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 2 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): Box 715

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAY	B.	TAYLOR	Nov. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 17, 1916	53		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor	Building	Glenns Ferry, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel B. Taylor	Kansas	Martha Biehl	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW II	518-10-3937	x Albert D. Taylor	Mountain Home, Idaho Box 715

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-20, 1969 *to* 11-20, 1969, *that I last saw the deceased alive on* 11-20, 1969, *and that death occurred at* 9:05 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
704 [signature]	Boise, Idaho	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Bremation 2	11-24-69	Mtn View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2 1969	Myrtle Palmer	[signature]	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM OH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 - 1969
FEB 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5007
Local Reg. No. 863
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 3103 Tamarack Dr.

3. NAME OF DECEASED (Type or Print) a. (First): THELMA	b. (Middle): LEONA	c. (Last): WOLFGANG	4. DATE OF DEATH (Month) (Day) (Year): Nov. 20, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Feb. 26, 1904	9. AGE (In years last birthday): 65 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Beattie, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank James	BIRTHPLACE: Illinois	14. MOTHER'S MAIDEN NAME: Almira Marks	BIRTHPLACE: Illinois	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-46-1298	17. INFORMANT'S OWN SIGNATURE: X Gary B. Wolfgang	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4310

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral Hemorrhage 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): Mitral Heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/27, 1968, *to* 11/20, 1969, *that I last saw the deceased alive on* 11/20, 1969, *and that death occurred at* 6 p *m., from the causes and on the date stated above.*

23a. SIGNATURE 306 [signature] (Degree or title)	23b. ADDRESS: Boise, Ida	23c. DATE SIGNED: 11/22/69	
24a. BURIAL, CREMATION REMOVAL (Specify): Burial	24b. DATE: 11/22/1969	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Nov. 26, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Gaul Waggoner	LICENSE NO.: E- 422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5008
Local Reg. No. 855
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 26 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Boise
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2324 North 16 th.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Buck	Roy	Dillon	Nov.	21	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	January 20, 1933	36		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Repacker	Associad Foods INC	Oroville, California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
W.A. (Bill) Dillon Sr.	Salt Lake City, Utah	Doris E. Stahl	Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		X Shelia R. Dillon	2324 N 16 Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 1538 Adenoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, 68, *to* Nov, 19 69, *that I last saw the deceased alive on* Nov 21, 1969, *and that death occurred at* 3,00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
654 M.D.	425 W Bannock	11/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 25, 1969	Dry Creek	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 25 1969	Myrtle Palmer	Eric Byram	E533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5009
Local Reg. No. 859
Reg. Dist. No. 370

RECEIVED
NOV 26 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 011 ADA	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; LENGTH OF STAY (In this place) 65 Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes 002	d. STREET ADDRESS (If rural, give location) 101½ North 10th.

3. NAME OF DECEASED (Type or Print) a. (First) Mabel	b. (Middle) Florance	c. (Last) Johns	4. DATE OF DEATH (Month) Nov. (Day) 21 (Year) 1969		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 17, 1887	9. AGE (In years last birthday) 83	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Council Grove, Kansas	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Roberts	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Bertha Unknown	BIRTHPLACE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE *Arthur L. Johns	ADDRESS		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral + cardio-	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	vascular arteriosclerosis	unkn-
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 11-18, 1969, *to* 11-21, 1969, *that I last saw the deceased alive on* 11-21, 1969, *and that death occurred at* 60 *m., from the causes and on the date stated above.*

23a. SIGNATURE W. D. Forney 173 (Degree or title) MD	23b. ADDRESS 425 Bannock Boise	23c. DATE SIGNED 11-24-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 23, 1969	24c. NAME OF CEMETERY OR CREMATORY Morris Hill	24d. LOCATION (City, town, or county) Boise (State) Idaho
DATE REC'D BY LOCAL REG. Nov. 25 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Erle Byram	LICENSE NO. E533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5010
Local Reg. No. 879
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2120 West Jefferson

3. NAME OF DECEASED (Type or Print): a. (First) SAMUEL b. (Middle) ARTHUR c. (Last) RULE

4. DATE OF DEATH (Month) (Day) (Year): 11-21-69

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 12-7-1890

9. AGE (In years last birthday): 78
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Boise City

11. BIRTHPLACE (State or foreign country): Heppner, Oregon

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: No record
BIRTHPLACE: Ireland

14. MOTHER'S MAIDEN NAME: no record
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Non
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 07 8744A

17. INFORMANT'S OWN SIGNATURE: X Edna S. Rule
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: (Sudden)

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary atherosclerosis
~~DUE TO (c)~~

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Far advanced Obstructive Pulmonary Emphysema

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 5-3, 19 67, to 11-21, 69, that I last saw the deceased alive on 11-21, 69, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE: M. E. Coppel 094 (Degree or title): MD
23b. ADDRESS: 311 Idaho St Boise
23c. DATE SIGNED: 12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec 3 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 4 - 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5011
Local Reg. No. 860
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 50 Years

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1014 Longmont

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	P.	Bonner	11	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	White	Married	Nov. 29 1898	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retiered 25	Same	Moore, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Patrick J. Bonner	Ireland	Mary E. Mathews	Spanish Fork Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		x Mae C Bonner	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 492X Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 2-3 mos.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema — 4 Yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* APRIL, 1966, *to* NOV 22, 1969, *that I last saw the deceased alive on* NOV 21, 1969, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J.B. Patterson MD	1203 Broadway Boise	11-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-25-69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 25 1969	Myrtle Palmer	Otto B. Bergam	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 1969

JUL 1 1975

MAR 27 1995

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5012
Local Reg. No. 854
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): one day
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke's Hosp. 303

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1331 So. Cole Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	H	Barrett	Nov 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	8-15-1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Construction	Warsaw, Virginia	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lynwood Barrett	Newland, Virginia	Carey Morris	Newland, Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
W.W.II		225 18 1862	Alice V. Barrett	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	4319 Cerebral Hemorrhage	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Aortic Stenosis & Insufficiency	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 22 Nov, 19 69, *to* 23 Nov, 19 69, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bruce Mordy MD 368	2429 N Cole Road	25 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-25-69	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 25 1969	Myrtle Palmer	Conway Grant	E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM OH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

2429 No Cole Rd

Mordy

3.

NOV 25 1969

NOV 28 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5013
Local Reg. No. 157
Reg. Dist. No. 371

BIRTH NO.

RECEIVED DEC 3 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 01 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION Sunset Nursing Home 735

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1016 N. 20th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Virginia	Elizabeth	Owen	Nov. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	May 14, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Calloway Co., Mo.	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry P. Romans	Virginia	Sarah Wilson	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE 2	ADDRESS
No		Harold Owen	Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Vascular Disease — 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — Several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/7/69, 19___, *to* 11/23/69, 19___, *that I last saw the deceased alive on* 11/23/69, 19___, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	1703 Hill Road, Boise	12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	25. EMBALMER	LICENSE NO.
Burial	11/25/69	Morris Hill Cemetery	Boise, Idaho	[signature]	E-422

DATE REC'D BY LOCAL REG.: Dec. 2, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
FIRM NAME: Alden Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 28 1969 Bureau of Vital Statistics

State File No. 5014
Local Reg. No. 864
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 3410 Apple Blossom Lane

3. NAME OF DECEASED (Type or Print)	a. (First) CYTHA	b. (Middle) BELL	c. (Last) STEPHENS	4. DATE OF DEATH (Month) (Day) (Year) Nov. 23, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Sept. 19, 1892	9. AGE (In years last birthday): 77; IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Gamma, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Newton A. Barr	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Melvina Tetrick	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-07-8372	17. INFORMANT'S OWN SIGNATURE: A X Trula Y. Stephens	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5322

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gastric Hemorrhage

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Penetrating duodenal ulcer

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Coronary insufficiency Recent Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION: Arterial bleeding from ulcer site	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 12, 1969, *to* Nov 23, 1969, *that I last saw the deceased alive on* Nov 22, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: C. C. Johnson 261 (Degree or title) MD.	23b. ADDRESS: Boise Idaho	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 11/27/69	24c. NAME OF CEMETERY OR CREMATORY: Inglewood Mem. Park	24d. LOCATION (City, town, or county) (State): Inglewood, California
DATE REC'D BY LOCAL REG.: Nov. 26, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Frank Waggoner	LICENSE NO.: E-422

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5015
Local Reg. No. 880
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 19 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 316 Hot Springs Drive 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 316 Hot Springs Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	A.	BUHLER	Nov. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 24, 1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 22	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner - Engine and	Parts Rebuilders	Big Stone City, S. D.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jackson Buhler	Switzerland	Emma Louise Lenz	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
Yes / WW I 3	518-07-5424	x Clara Buhler 316 Hot Springs Dr. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial dysfunction — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery Heart Disease
DUE TO (c) Coronary artery athero Sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 1950 19 *to* Nov 27 19 69 *that I last saw the deceased alive on* NOV 24 - 1969 *and that death occurred at* 6:13 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John T. Carpenter 094	M.D.	311 Idaho St - Boise	Dec 1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-28-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 5, 1969	Myrtle Palmer	Norvell L. Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

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DEC 5 1969

DEC 7 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5016
Local Reg. No. 873
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital (DOA)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
d. STREET ADDRESS (If rural, give location): Rt. # 1, Ballantyne Lane

3. NAME OF DECEASED (Type or Print): a. (First) Opal; b. (Middle) Pearl; c. (Last) Kinsey

4. DATE OF DEATH (Month) (Day) (Year): Nov. 25, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 25, 1905

9. AGE (In years last birthday): 64
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Licensed Practical Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (State or foreign country): Wayne County, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Snyder
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Bessie Bonowitz
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Christy D. Kinsey
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Suddenly

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes M. — 10+ years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-26, 1960, to March 28, 1969, that I last saw the deceased alive on March 28, 1969, and that death occurred at Nov. 25 m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] 318 (Degree or title) MD

23b. ADDRESS: 401 N 26 Boise Idaho

23c. DATE SIGNED: 12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/28/1969

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 3, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. E. Alden

LICENSE NO.: 299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
BIRTH NO DEC 3 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5017
Local Reg. No. 869
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1217 Hervey Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELIZABETH	W.	SERVIS	Nov. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Aug. 20, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Perham, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Muehlenbein	Germany	Anna Kerrbs	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE
No	---	518-07-3036	2810 Clarendon. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) SARCOMA — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug. 13, 1969 *to* Nov. 25, 1969, *that I last saw the deceased alive on* Nov. 25, 1969, *and that death occurred at* 9:20 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. W. Burkholder, M.D.	848 La Cassia, Boise	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-28-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 2, 1969	Myrtle Palmer	Gary A. Brewer	E-526

FIRM NAME SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5018
Local Reg. No. 872
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
DEC 3 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1415 Joyce St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1415 Joyce St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FLOYD	O.	BEDDALL	Nov. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 25, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Examiner	Internal Revenue	Trimbelle, Wisc.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John T. Beddall	Wisc.	Nancy Cornelison	Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI	518-07-4481	Mrs. Floyd Beddall	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 1967 *to* Nov 1969, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 8:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] -654 (Degree or title) MD	425 W Bannock	12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-29-69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 3, 1969	Myrtle Palmer	G. W. Waters [signature]	E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

DEC 3 - 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics
DEC 2 1969

State File No. 5019
Local Reg. No. 136
Reg. Dist. No. 421

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 17 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: OREGON
b. COUNTY: MALHEUR
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ONTARIO
d. STREET ADDRESS (If rural, give location): 743 FORTNER

3. NAME OF DECEASED (Type or Print): a. (First) DUANE; b. (Middle) LEROY; c. (Last) FENN

4. DATE OF DEATH (Month) (Day) (Year): NOVEMBER 26, 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 9/3/ 1932

9. AGE (In years last birthday): 37
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: SAME

11. BIRTHPLACE (State or foreign country): NYSSA, OREGON

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CARL J. FENN
BIRTHPLACE: UTAH

14. MOTHER'S MAIDEN NAME: IDA HARRIS
BIRTHPLACE: NEBRASKA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): KOREAN CONFLICT

16. SOCIAL SECURITY NO.: 543 36 1603

17. INFORMANT'S SIGNATURE: Doreen Bentley
ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hydrocephalus. — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic meningitis. — 4 yrs.
DUE TO (c) Coccidioides immitis. — 4 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: VA

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. [redacted] attended the deceased from NOVEMBER 9, 1969, to NOVEMBER 26, 1969 [redacted], and that death occurred at 11:30a m., from the causes and on the date stated above.

23a. SIGNATURE: FRED B. HINE, M.D. (497) Fred B. Hine MD (Degree or title)

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 11/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-29-1969

24c. NAME OF CEMETERY OR CREMATORY: Owyhee Cemetery

24d. LOCATION (City, town, or county): Rural Nyssa, (State): Oregon

DATE REC'D BY LOCAL REG.: Dec. 2 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Robert H Bertelson

FIRM NAME: Bertelson-Lienkamper Ontario, Ore.

LICENSE NO.: 2220re.

Federal Security Agency
United States Public Health Service
FORM UH-63021

DEC 3 1969
DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5020
Local Reg. No. 873
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: ADA 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO 13 b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE	c. LENGTH OF STAY (In this place):
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST ALPHONSUS HOSPITAL 003	d. STREET ADDRESS (If rural, give location): ROUTE TWO

3. NAME OF DECEASED (Type or Print) a. (First): DAVID	b. (Middle): C	c. (Last): PAUSTIAN	4. DATE OF DEATH (Month) (Day) (Year): 11-26-69		
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED	8. DATE OF BIRTH: 12 23 1885	9. AGE (In years last birthday): 84	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: self emp.	11. BIRTHPLACE (State or foreign country): Missouri	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: Christopher A. Paustian,	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Mary Lowman	BIRTHPLACE: no record		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 486 40 5586A	17. INFORMANT'S OWN SIGNATURE: X J. C. Paustian	ADDRESS:		

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary heart disease	3 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	advanced emphysema	5 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* apr 1, 1969, *to* death, 19____, *that I last saw the deceased alive on* 26 Nov, 1969, *and that death occurred at* 7:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE 046 C. R. Blackburn MD (Degree or title)	23b. ADDRESS: Boise Ida	23c. DATE SIGNED: Dec 2, 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Dec. 1, 1969	24b. DATE: 12-1-69 Burial	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale	24d. LOCATION (City, town, or county): Boise (State): Idaho
DATE REC'D BY LOCAL REG.: Dec. 3 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Conway Grant	LICENSE NO.: E478

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 - 1969

DEC 11 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5021
Local Reg. No. 159
Reg. Dist. No. 371

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: ADA 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: GEM 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE c. LENGTH OF STAY (In this place): 11 DAYS	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): EMMETT
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO 004	d. STREET ADDRESS (If rural, give location): 119 EAST 5TH STREET

3. NAME OF DECEASED (Type or Print)	a. (First) JOHN	b. (Middle) E.	c. (Last) PERRIGO	4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 26, 1969
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED	8. DATE OF BIRTH: JUNE 2, 1872	9. AGE (In years last birthday): 97 — IF UNDER 1 YR. Months — Days — IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER 04	10b. KIND OF BUSINESS OR INDUSTRY: FARMING	11. BIRTHPLACE (State or foreign country): EMPORIA, KANSAS	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: WILLIAM J. PERRIGO	BIRTHPLACE: ILLINOIS	14. MOTHER'S MAIDEN NAME: MARTHA SHAW	BIRTHPLACE: OHIO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): SAW 1	16. SOCIAL SECURITY NO.: 518-52-7977	17. INFORMANT'S OWN SIGNATURE: Frances J. Bentley	ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Subdural hematoma.	2 months.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Trauma.	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic brain syndrome.	2 yrs.

8871

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT XX SUICIDE HOMICIDE 1 (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Home 01	21c. (CITY, TOWN, OR TOWNSHIP): Emmett 13231 (COUNTY): Gem (STATE): Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): October 1969 m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR? Spontaneous fall	

22. VA attended the deceased from NOVEMBER 15, 1969, to NOVEMBER 26, 1969 ~~[illegible]~~ ~~[illegible]~~, and that death occurred at 7:07 p m., from the causes and on the date stated above.

23a. SIGNATURE: FRED B. HINE, M.D. 597 (Degree or title) Fred B. Hine, MD	23b. ADDRESS: VA CENTER, BOISE, IDAHO	23c. DATE SIGNED: 11-28-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): burial 3	24b. DATE: 11-29-69	24c. NAME OF CEMETERY OR CREMATORY: Emmett	24d. LOCATION (City, town, or county) (State): Emmett, Idaho
DATE REC'D BY LOCAL REG.: Dec. 5 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Walter Potter	LICENSE NO.: E-445

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME THE BEATTY CHAPEL Emmett, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 9 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5022
Local Reg. No. 874
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 011 Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location) 4620 Mason Dr.

3. NAME OF DECEASED (Type or Print)	a. (First) Herbert	b. (Middle) Maine	c. (Last) Shoun	4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 19, 1898	9. AGE (In years last birthday) 70 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Educator 12	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mountain City, Tenn.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter G. Shoun	BIRTHPLACE Mountain City, Tenn.	14. MOTHER'S MAIDEN NAME Victoria Cole	BIRTHPLACE Mountain City. Tenn.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 1 3	16. SOCIAL SECURITY NO. 518-46-1718	17. INFORMANT'S OWN SIGNATURE Leona P. Shoun	ADDRESS 4620 Mason Dr.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of prostate — INTERVAL BETWEEN ONSET AND DEATH 6+ yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12-5-63	19b. MAJOR FINDINGS OF OPERATION Cancer of Prostate - TURP.	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 3, 1963, *to* death, 19____, *that I last saw the deceased alive on* Nov 27, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE X B Jeppesen 259 (Degree or title) MD	23b. ADDRESS Boise Idaho	23c. DATE SIGNED 12/2/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/1/1969	24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Dec. 3, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Earl Waggoner	LICENSE NO. E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 - 1969

JAN 2 2 1970
APR 1 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5023
Local Reg. No. 875
Reg. Dist. No. 370

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 4 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1902 Taggert Street

3. NAME OF DECEASED (Type or Print)
a. (First) Mamie
b. (Middle) Viola
c. (Last) Stone

4. DATE OF DEATH (Month) (Day) (Year) November 27 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH August 8 1896
9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 28
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Vanetta, Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harper BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Steven C. Muzzy - 1902 Taggert St Boise, Idaho ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
(c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Recent Pulmonary Embolus - Recent Thrombophlebitis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Operation for fractured hip
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 12, 1969, *to* Nov 27, 1969, *that I last saw the deceased alive on* Nov 26, 1969, *and that death occurred at* 6 A *m., from the causes and on the date stated above.*

23a. SIGNATURE C. C. Johnson 261 (Degree or title) MD
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE December 1 1969
24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery
24d. LOCATION (City, town, or county) Baker (State) Oregon

DATE REC'D BY LOCAL REG. Dec. 3, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER A. E. Alden LICENSE NO. 299

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5024
Local Reg. No. 870
Reg. Dist. No. 870

BIRTH NO.

RECEIVED
DEC 3 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Calif. 05
b. COUNTY: Ventura 565
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ventura
d. STREET ADDRESS (If rural, give location): 972 Phoenix St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	J	Wallace	Nov. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Sept. 30, 1963	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	--------	Lancaster, Calif.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jerry L. Wallace	California	Shirley Cox	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Jerry L. Wallace	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 2730 Ca Pulmonale — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cystic fibrosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.* D.O.A.

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
542 W2 Venning MD	Boise	12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11/28/1969	Ivy Lawn Mem. Park	Ventura, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Myrtle Palmer	Earl Waggoner	E-422

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden Waggoner Chapel

DEC 11 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Miner's
1333 W. Jefferson. 343-4081

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5025
Local Reg. No. 876
Reg. Dist. No. 320

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 01 — DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (If not in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Restful Manor Nursing Home 292

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13 — b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1416 N. 13th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ella		Woods	Nov. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Never Married	Jan. 23, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Research Chemist in Agr. 08	U. of Idaho	Ada County, Idaho	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph E. Woods	Old Town, Maine	Elizabeth Riddell	Dollar, Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-54-0397	x Mrs Edith Tate	RT. 1 Eagle, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral thrombosis	5 3/4 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	cerebral arteriosclerosis	(??) yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Aortic stenosis	(??) yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb, 1964, *to* Nov. 27, 1969, *that I last saw the deceased alive on* Nov. 20, 1969, *and that death occurred at* 12 noon, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul T. Miner 364 M.D.	1333 W. Jefferson St. Boise, Idaho 83702	12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/1/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 3 1969	Myrtle Palmer	J. U. Magee	E-390

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

FEB 17 1970

MAR 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 2 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 29 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

OCT 07 2014

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5026
Local Reg. No. 162
Reg. Dist. No. 371

RECEIVED DEC 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place): 28 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: V.A.HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 309 E. 36th Street

3. NAME OF DECEASED (Type or Print): a. (First) LESTER b. (Middle) F. c. (Last) ANDERSON
4. DATE OF DEATH: (Month) NOV. (Day) 28, (Year) 1969
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: DEC.6,1894
9. AGE (In years last birthday): 74
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LOCKSMITH
10b. KIND OF BUSINESS OR INDUSTRY: SAME
11. BIRTHPLACE (State or foreign country): BEAVER CITY, OKLA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: FREDERICK ANDERSON
BIRTHPLACE: GA.
14. MOTHER'S MAIDEN NAME: FLORENCE PERRY
BIRTHPLACE: VA.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 517 20 67 07
17. INFORMANT'S OWN SIGNATURE AND ADDRESS: V.A.HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4412

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 1 Month

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Abdominal aortic aneurysm — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Oct. 31, 1969
19b. MAJOR FINDINGS OF OPERATION: Abdominal aortic aneurysm
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I attended the deceased from Oct. 31, 1969, to November 28, 1969, and that death occurred at 8:10a.m., from the causes and on the date stated above.

VA

23a. SIGNATURE (Degree or title): R. J. BUNGARD, M.D. 591
23b. ADDRESS: V.A.HOSPITAL, BOISE, IDAHO
23c. DATE SIGNED: 11-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Buried
24b. DATE: 12-1-69
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Memorial Gardens
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 11, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Clyde J. Vassar
LICENSE NO.: E-535

FIRM NAME: CLOVERDALE FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, includjng the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 5027
Local Reg. No. 889
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA DEC 12 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Accident near residence 805 Warren St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 805 Warren St

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WALTER	C	EDWARDS	NOV. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	WIDOWED	DEC 28, 1882	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	BUILDING	KILBOURNE, WISCONSIN	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
WILLIAM D. EDWARDS	TROY, NEW YORK	MARY HERRICK	TROY, NEWYORK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519 01 3647	X Betty N. La Reyne	

8147

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed left Chest, Internal Bleeding. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Left Shoulder Broken, Crushed. Right Leg broken. — Brief.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
	04	130 11

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR? While walking. Struck by Auto, Dragged, & Rolled.
m.		

22. *I hereby certify that I attended the deceased from* Did Not See to Alive, 19, *that I last saw the deceased alive on* , 19 *and that death occurred at* 715 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S&S E. Paris	Coroner	3720 Meadow Drive, Boise.	12-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	DEC. 3, 1969	CLOVERDALE	BOISE IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 9, 1969	Myrtle Palmer	Conway Grant	E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5028
Local Reg. No. 884
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada o/o
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At home ooo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada o/o
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Flora b. (Middle) c. (Last) Reedy

4. DATE OF DEATH: Month 12 Day 28 Year 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 11, 1899
9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife o/
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: E. Bickford BIRTHPLACE: Mo.
14. MOTHER'S MAIDEN NAME: Unknown BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-26-8972
17. INFORMANT'S OWN SIGNATURE: Harry O. Reed. ADDRESS: Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) She had been takeing Treatments and Medicine for Heart Condition. Months.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Did Not See Alive, 19___, that I last saw the deceased alive on ___ and that death occurred at 8P m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] SR3 (Degree or title) Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise,
23c. DATE SIGNED: 12-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-6-69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 9, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Jack H. Green
LICENSE NO.: 528
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 9 1969

3

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5029
Local Reg. No. 882
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY 01 Ada			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho	b. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise	c. LENGTH OF STAY (In this place) 2 Hrs.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003			d. STREET ADDRESS (If rural, give location) 3527 Federal Way	
3. NAME OF DECEASED (Type or Print) a. (First) Robert	b. (Middle) L	c. (Last) Abrams	4. DATE OF DEATH (Month) (Day) (Year) 11-30-69	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 5, 1916	9. AGE (In years last birthday) 53
IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 27	10b. KIND OF BUSINESS OR INDUSTRY Self employed	11. BIRTHPLACE (State or foreign country) Clarksburg Indiana	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chas. Abrams	BIRTHPLACE Indiana	14. MOTHER'S MAIDEN NAME Nancy Gillespie	BIRTHPLACE Indiana	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 559-28-0090	17. INFORMANT'S OWN SIGNATURE Marvin Stoker	ADDRESS 7304 Cedarwood Dr Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7080

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Conjunctivitis Edema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 30, 1969, *to* Nov 30, 1969, *that I last saw the deceased alive on* Nov 30, 1969, *and that death occurred at* 4:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 333 Masonic	23b. ADDRESS 808 La Cima Dr. Boise	23c. DATE SIGNED Dec 8-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE 12/1/69	24c. NAME OF CEMETERY OR CREMATORY Twin Falls	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho
DATE REC'D BY LOCAL REG. Dec. 8, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer / LRD	25. EMBALMER Andrew P. Stankowski	LICENSE NO. E-527

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME Mountain View Funeral Home, Boise

AUG 0 3 2000 DEC 8 1969

DEC 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 1 2 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

JUN 8 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5030
Local Reg. No. 871
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 001 — DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital 002

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 911 Alturas St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Josie	F.	Jennings	Nov. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced	Feb. 21, 1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cashier 25	Restaurant & Retail Dept. Store	Boise, Ida.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Phillitus Chinn	Unknown	Millie Jane Chapman	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-01-3019	Florence Hartley	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 2 yrs
DUE TO (c) Arteriosclerotic Vascular Disease — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arthritis — 6 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3/6/65, 19__, *to* 11/30/69, 19__, *that I last saw the deceased alive on* 11/30/69, 19__, *and that death occurred at* 12:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 516	703 Hill Road Boise	12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/3/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 5031
Local Reg. No. 161
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA — DEC 12 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 545 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: BUTTE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ARCO
d. STREET ADDRESS (If rural, give location): GENERAL DELIVERY

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLAUDE	W.	WINWARD	NOVEMBER 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	WIDOWED	MAY 20, 1894	75	---	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER	FARMING	PAYSON, UTAH	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
CHARLES WINWARD	PAYSON, UTAH	FLORENCE SARGENT	PAYSON, UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI	519-26-5122		VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cachexia	3 Months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Squamous cell carcinoma of epiglottis	18 Months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 6, 1968	Squamous cell carcinoma of epiglottis	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from JUNE 4, 19 68, to NOVEMBER 30, 19 69, and that death occurred at 10:30p m., from the causes and on the date stated above.

23a. SIGNATURE AND DEGREE OR TITLE	23b. ADDRESS	23c. DATE SIGNED
Raymond J. Bungard RAYMOND J. BUNGARD, M.D. 597	VA CENTER, BOISE, IDAHO	12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Dec. 2, 1969	Arco Cemetery	Arco Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 9 1969	Myrtle Palmer	Gary A. Summers	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5032
Local Reg. No. 890
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 023

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2710 Woody Drive

3. NAME OF DECEASED (Type or Print) a. (First) Jacquelyn b. (Middle) L. c. (Last) Yoelin

4. DATE OF DEATH (Month) (Day) (Year) Nov. 30, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 1, 1948

9. AGE (In years last birthday) 21
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ontario, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Donald E. Lukehart
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Delora
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Donald E. Lukehart
ADDRESS Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gun Shot Thru Head. — INTERVAL BETWEEN ONSET AND DEATH: 15 Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Family Quarrels. Husband arrested.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) 3 Homicide

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 31

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 011

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Did Not See Alive, 19, that I last saw the deceased alive on, 19, and that death occurred at 218A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 553 + Coroner

23b. ADDRESS 3720 Meadow Drive, Boise

23c. DATE SIGNED 12-3-69.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-3-69

24c. NAME OF CEMETERY OR CREMATORY Cloverdale

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. Dec. 9, 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER

LICENSE NO. 366

FIRM NAME Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 2 - 1970

JUL 17 1997

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5033
Local Reg. No. 18
Reg. Dist. No. 300

BIRTH NO. 69-10945

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Adams 020
b. CITY OR TOWN: Council
b. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 017

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Indian Valley
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LYNN	N.	REIMERS	Nov.	2	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married	Nov.1, 1969			1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	Infant	Council, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Darrel Reimers	Weiser, Idaho	Diane Thompson	Albany, Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		Darrel Reimers	Indian Valley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Succinyl Choline - Intoxication — INTERVAL BETWEEN ONSET AND DEATH: 18 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 11-1, 1969, *to* 11-2, 1969, *that I last saw the deceased alive on* 11-2, 1969, *and that death occurred at* 7:15 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D. 154	Council, Idaho	11-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 2, 1969	Indian Valley, Cem.	Indian Valley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-69		R. Dale Thomason	E-388

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 3 1969 Bureau of Vital Statistics

State File No. 5034
Local Reg. No. 371
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello; STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Nursing Home 294	d. STREET ADDRESS (If rural, give location) 1224 S. 2nd

3. NAME OF DECEASED (Type or Print) a. (First) ANDREW	b. (Middle)	c. (Last) CONNER	4. DATE OF DEATH (Month) (Day) (Year) May 14, 1969		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 28,1888	9. AGE (In years last birthday) 80	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 08	10b. KIND OF BUSINESS OR INDUSTRY I.S.U.	11. BIRTHPLACE (State or foreign country) Tennesee	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Clinton Conner	BIRTHPLACE Tenn.	14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-05-8869	17. INFORMANT'S OWN SIGNATURE Clinton Conner	ADDRESS Calif. Huntington Pk.		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Adeno Carcinoma of Prostate	4 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic Heart + Brain Disease	5-10 years

19a. DATE OF OPERATION Jan 1969	19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Sigmoid Colon (resected) prob. metastatic	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 30, 1964 *to* May 14, 1969, *that I last saw the deceased alive on* May 5, 1969, *and that death occurred at* 4 55 *m., from the causes and on the date stated above.*

23a. SIGNATURE Richard E. Ostler MD 406 (Degree or title)	23b. ADDRESS 246 N. 18th Pocatello Idaho	23c. DATE SIGNED 12-1-1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 16-69	24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.	24d. LOCATION (City, town, or county) (State) Pocatello, Idaho
DATE REC'D BY LOCAL REG. DEC 2 1969	REGISTRAR'S SIGNATURE Gloria Dopeta	25. EMBALMER John P. Grimm	LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended 1/21/70

Certificate of Death

STATE OF IDAHO

State File No. 5035
Local Reg. No. 354
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 09

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Whitman Hotel

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Edward	Lee	Collins	November 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Separated	August 5, 1905	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Building Custodian 06	KSEI Radio Station	Edgefield, South Carolina	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis W. Collins	South Carolina	Alice Jefferson	South Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War II 4	300-07-1720	Lewis W. Collins (signed)	Detroit, Michigan

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Ca of esophogus — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 Feb., 1969, *to* Nov. 3, 1969, *that I last saw the deceased alive on* Nov. 3, 1969, *and that death occurred at* 2:25a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. G. Crandall (signed) 113	M. D.	Pocatello, Idaho	Nov. 5, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 5, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Gloria Dopita (signed)	Jack Henderson (signed)	E-349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Henderson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

AFFIDAVIT

STATE OF IDAHO)
: ss.
County of Bannock)

HENRY H. FLETCHER, being first duly sworn, deposes and says:

That he makes this affidavit to correct Item Number 7 in the Death Certificate of EDWARD LEE COLLINS; that he knew Edward Lee Collins during his lifetime and was his employer; that he has been advised many times by Edward Lee Collins that he was separated from his wife but that they were never divorced; your affiant has further talked to Edna V. Collins, wife of Edward Lee Collins, who has further advised your affiant that while she and Mr. Edward Lee Collins had separated there had never been a divorce action filed.

Henry H Fletcher

SUBSCRIBED AND SWORN TO Before me this 13th day of January, 1970.

Alice Greene

NOTARY PUBLIC for Idaho
Residing at Pocatello, Idaho

(SEAL)

AFFIDAVIT

STATE OF IDAHO)
: ss.
County of Bannock)

HENRY H. FLETCHER, being first duly sworn, deposes and says:

That he makes this affidavit to correct Item Number 7 in the Death Certificate of EDWARD LEE COLLINS; that he knew Edward Lee Collins during his lifetime and was his employer; that he has been advised many times [illegible] Edward Lee Collins had separated there had never been a divorce action filed.

never divorced; your affiant has further talked to Edna V. Collins, wife of Edward Lee Collins, who has further advised your affiant that while she and Mr.

[signature]

SUBSCRIBED AND SWORN TO Before me this 13th day of January, 1970.

NOTARY PUBLIC for Idaho
Residing at Pocatello, Idaho

(SEAL)

AFFIDAVIT

STATE OF CALIFORNIA)
: ss.
County of Los Angeles)

EDNA V. COLLINS, being first duly sworn, deposes and says:

That she makes this Affidavit in order to correct Item Number 7 of the Certificate of Death of Edward Lee Collins, which said Item 7 specifies that Edward Lee Collins was divorced. Your affiant is the wife of Edward Lee Collins and while she and the deceased were separated there had never been a divorce action filed and the parties were never divorced.

Edna V Collins

SUBSCRIBED AND SWORN TO Before me this 16th day of January, 1970.

Paul Epps Jr.
NOTARY PUBLIC for California
Residing at Los Angeles, California

(SEAL)

OFFICIAL SEAL
PAUL EPPS, JR.
NOTARY PUBLIC CALIFORNIA
LOS ANGELES COUNTY
My Commission Expires Feb. 15, 1972
8115 So. Central Ave., Los Angeles, Calif. 90001

OFFICIAL SEAL
PAUL EPPS, JR.
NOTARY PUBLIC CALIFORNIA
LOS ANGELES COUNTY
My Commission Expires Feb. 15, 1972
8115 So. Central Ave., Los Angeles, Calif. 90001

AFFIDAVIT

STATE OF CALIFORNIA)
County of [redacted]) ss.

EDNA V. COLLINS, being first duly sworn, deposes and says:

That she makes this Affidavit in order to correct Item Number 9 of the Certificate of Death of Edward Lee Collins, which said Item 7 specifies Collins and while she and the deceased were married there had never been a divorce action filed and the parties were never divorced.

[redacted]

SUBSCRIBED AND SWORN TO Before me this [redacted] day of January, 1970.

[redacted]
NOTARY PUBLIC [redacted]
Residing at [redacted] California

(SEAL)

OFFICIAL SEAL
PAUL EPPS, JR
NOTARY PUBLIC CALIFORNIA
LOS ANGELES COUNTY
My Commission Expires Feb. 15, 1972
8115 So. Central Ave., Los Angeles, Calif. 90001

OFFICIAL SEAL
PAUL EPPS, JR
NOTARY PUBLIC CALIFORNIA
LOS ANGELES COUNTY
My Commission Expires Feb. 15, 1972
8115 So. Central Ave., Los Angeles, Calif. 90001

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5035
Local Reg. No. 354
Reg. Dist. No. 510

BIRTH NO.

NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (If in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Whitman Hotel

3. NAME OF DECEASED (Type or Print)
a. (First): EDWARD
b. (Middle): LEE
c. (Last): COLLINS

4. DATE OF DEATH (Month) (Day) (Year): November 3 1969

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: August 5, 1905
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Custodian
10b. KIND OF BUSINESS OR INDUSTRY: K.S.E.I. Radio Station
11. BIRTHPLACE (State or foreign country): Edgefield, South Car.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Lewis W. Collins — BIRTHPLACE: So. Carolina
14. MOTHER'S MAIDEN NAME: Alice Jefferson — BIRTHPLACE: So. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 300-07-1720
17. INFORMANT'S OWN SIGNATURE: Lewis W. Collins — ADDRESS: Detroit, Mich

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Ca of esophagus — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 Feb, 1969, *to* Nov. 3, 1969, *that I last saw the deceased alive on* Nov. 3, 1969, *and that death occurred at* 2:25 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Nov. 5, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: NOV 1 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

NOV 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 2 1 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 1 3 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

State File No. 5036
Local Reg. No. 355
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 002	d. STREET ADDRESS (If rural, give location) 148 Toponce

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPHINE	b. (Middle)	c. (Last) WHITING	4. DATE OF DEATH (Month) (Day) (Year) Nov. 4, 1969	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar. 21, 1887	9. AGE (In years last birthday) 82 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Wallsburg, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William G. Nuttall	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Juliet Wall	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) XXXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE F. Heber Denison	ADDRESS	

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH chronic

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cholelithiasis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* January 19, 19 69, *to* November 4, 19 69, *that I last saw the deceased alive on* March 13, 19 69, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 077 (Degree or title) L. S. CALL, MD	23b. ADDRESS Box 852 - Pocatello, Ida	23c. DATE SIGNED 11-12-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial 3	24b. DATE Nov. 4, 1969	24c. NAME OF CEMETERY OR CREMATORY Wood Mortuary	24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho
DATE REC'D BY LOCAL REG. NOV 1 2 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER	LICENSE NO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5037
Local Reg. No. 357
Reg. Dist. No. 510

RECEIVED NOV 20 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 306 North Sixth Avenue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 306 North Sixth Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): ROSA
b. (Middle): J.
c. (Last): ALLEN

4. DATE OF DEATH (Month) (Day) (Year): November 5 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 29, 1876
9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Thatcher Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joshua James Call — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Rosa Louise Atkinson — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Frank P. Allen — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Oct-1969
19b. MAJOR FINDINGS OF OPERATION: Ca of Pancreas
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 19 1969, *to* Nov. 5, 19 69, *that I last saw the deceased alive on* Nov. 5, 19 69, *and that death occurred at* 2:45 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 362 David C. Miller, M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Nov. 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: NOV 17 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson — LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: NOV 21 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

State File No. 5038
Local Reg. No. 358
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 03

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 03

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
STAY (In this place)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Bannock Memorial Hospital 018

d. STREET ADDRESS (If rural, give location) 1536 N. Garfield

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ADA	S.	KEIL	Nov. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Jan. 15, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Strecker	Russia	Elizabeth Unknown	Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Jacob Keil	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1820 Cancer of uterus (Endometrial)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, *to* Nov 10, 1969, *that I last saw the deceased alive on* Nov 10, 1969, *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David M Jones MD	527 South 12th Pocatello, Idaho	11-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov. 12-69	Mountainview Cem.	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 18 1969	Edna Acosta	John P. Downard	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 6 1969
MAR 3 1970
APR 2 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5039
Local Reg. No. 36C
Reg. Dist. No. 510

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 003
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 125 Roosevelt

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HERBERT		LUSHINSKY	Nov. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Oct. 7, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10 Union Pacific Railroad
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Platsmouth, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE: William Joseph Lushinsky
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Pauline Marie Kuickler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Herbert Wm Lushinsky ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Diabetes Mellitus. Arteriosclerotic heart disease with Pulmonary edema, severe. Hypertensive vascular disease.

INTERVAL BETWEEN ONSET AND DEATH: 7 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 14 1969 *to* November 10, 1969 *that I last saw the deceased alive on* November 10, 1969 *and that death occurred at* 12:20p m., *from the causes and on the date stated above.*

23a. SIGNATURE 029 (Degree or title)
23b. ADDRESS L. H. ANDERSON, M.D. 1448 E. CENTER, POCATELLO, IDAHO 83201
23c. DATE SIGNED 11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City or town, county) (State)
Burial	Nov.14,1969	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. DEC 2 1969
REGISTRAR'S SIGNATURE Gloria Dopeta
25. EMBALMER Theron Spillers
LICENSE NO. E-524
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

NOV 25 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5040
Local Reg. No. 374
Reg. Dist. No. 510

RECEIVED
DEC 11 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 519

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 202 Briscoe Lane

3. NAME OF DECEASED (Type or Print): a. (First) CARL; b. (Middle) JAMES; c. (Last) RHOADES

4. DATE OF DEATH (Month) (Day) (Year): November 10 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 2, 1910

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warehouseman 08

10b. KIND OF BUSINESS OR INDUSTRY: State Liquor Dept.

11. BIRTHPLACE (State or foreign country): Holton, Kansas

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Arthur Robert Rhoades
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Bertha York
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 519-07-5048

17. INFORMANT'S OWN SIGNATURE: (s) Edna Rhoades
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4209

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Ventricular fibrillation
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary artery disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Aortic stenosis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Feb 20, 1967, *to* Nov. 10, 1969, *that I last saw the deceased alive on* Nov. 10, 1969, *and that death occurred at* 5:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Calvin Buhler 069 (Degree or title) M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Dec. 4, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: DEC 5 1969
REGISTRAR'S SIGNATURE: Gloria Doyle
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1969

DEC 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 27 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 9 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5041
Local Reg. No. 363
Reg. Dist. No. 511

BIRTH NO.

NOV 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
c. LENGTH OF STAY (If not in this place): 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
d. STREET ADDRESS (If rural, give location): Box 284

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle):
c. (Last): DAY

4. DATE OF DEATH (Month) (Day) (Year): Nov. 11, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct 24, 1901
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Businessman 22
10b. KIND OF BUSINESS OR INDUSTRY: retail trade
11. BIRTHPLACE (State or foreign country): Downey, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Norman Day — BIRTHPLACE: Kaysville, Utah
14. MOTHER'S MAIDEN NAME: Mary Cathrine Bowman — BIRTHPLACE: Richmond, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W W II 4
16. SOCIAL SECURITY NO.: 518 18 5958
17. INFORMANT'S OWN SIGNATURE: Mrs. Erma Day — ADDRESS: Downey, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Generalized Arteriosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [ ] NO [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1951, *to* Nov 11, 1969, *that I last saw the deceased alive on* 11-11, 1969, *and that death occurred at* 12:55 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 070
23b. ADDRESS: Downey Id
23c. DATE SIGNED: 11.14.69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Downey Cemetery
24d. LOCATION (City, town, or county) (State): Downey, Idaho

DATE REC'D BY LOCAL REG.: 11-17-69
REGISTRAR'S SIGNATURE: Ila Mae Cunningham
25. EMBALMER: Douglas S. Webb — LICENSE NO.: 488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DEC 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post-office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5042
Local Reg. No. 356
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 030 NOV 17 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall Bureau of Vital Statistics c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) RAYMOND (RAY) b. (Middle) c. (Last) QUANDA		4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1969	
5. SEX Male	6. COLOR OR RACE Indian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Dec. 2, 1921
9. AGE (In years last birthday) 47	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 21 Heavy Equipment Operator	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Blackfoot, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jack Quanda	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Mary Sequint	BIRTHPLACE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II 4	16. SOCIAL SECURITY NO. 721 14 1969	17. INFORMANT'S OWN SIGNATURE Louise Quanda	ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Apparent Heart Attack — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — *, 19___, to* — *, 19___, that I ~~last~~ saw the deceased ~~alive~~ dead on* 11-11-69*, and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton John 53 4 (Degree or title) Coroner	23b. ADDRESS Bannock Co. Idaho	23c. DATE SIGNED 11-13-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov.14,1969	24c. NAME OF CEMETERY OR CREMATORY Gibson Cemetery	24d. LOCATION (City, town, or county) (State) Fort Hall, Idaho
DATE REC'D BY LOCAL REG. NOV 13 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Theron Miller	LICENSE NO. E-534

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

FEB 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5043
Local Reg. No. 359
Reg. Dist. No. 310

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 057
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 218

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 057
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 558 South Garfield Avenue

3. NAME OF DECEASED (Type or Print): a. (First) HULDA b. (Middle) CLARA c. (Last) WIGHT

4. DATE OF DEATH (Month) (Day) (Year): November 13 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: December 10, 1878

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Brigham City Utah

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Andrers M. Josephson
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Anna Anderson
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Dossa Cotant
ADDRESS: Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 485X Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: few weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility — chronic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Advanced arteriosclerotic heart disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April 22 1963, *to* Nov. 13, 1969, *that I last saw the deceased alive on* Nov. 13, 1969, *and that death occurred at* 8:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L S Call, MD 017
23b. ADDRESS: Box 852 Pocatello, Idaho
23c. DATE SIGNED: Nov. 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Garden
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG. NOV 24 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5044
Local Reg. No. 360
Reg. Dist. No. 511

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Interstate Hiway 15 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Wyoming 51
b. COUNTY Fremont 535
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Lander
d. STREET ADDRESS (If rural, give location) Fort Washakie Indian Reservation

3. NAME OF DECEASED (Type or Print) a. (First) CHARLOTTE b. (Middle) c. (Last) WETCHIE
4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Indian	Unknown	May 30, 1939	30		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife C/	Home	WYoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sage Wetchie	Wyoming	Mary Poogari	Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Ray Wetchie	Ft. Washakie, Wyo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Fracture Skull, Compound — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Internal Injuries
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple Severe Injuries & Fractures

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Interstate 15 06	13030 Bannock Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
11-15-69 8:50 p.m.		Car-Pedestrian Accident

22. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____, that I last saw the deceased alive on 11-15-69, 19____, and that death occurred at 8:50 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton John STB Coroner	Bannock Co. Ida.	11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Nov. 17-69	Ft. Washakie Cem.	Fremont County, Wyoming

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 20 1969	Gloria Dopita	John P. Downard	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

DEC 12 1969

Bureau of Vital Statistics

State File No. 5045
Local Reg. No. 376
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 015

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 910 North Lincoln

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOYCE	M.	SIMMONS	Nov. 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	married	Jan. 4, 1937	32		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Pocatello, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Melvin Apel	Montana	Mae Bentley	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Verl O Simmons	Pocatello, Idaho

5609

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Small bowel obstruction. — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Catatonic schizophrenic.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
None		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 14, 1969 to Nov. 16, 1969, that I last saw the deceased alive on Nov. 15, 1969, and that death occurred at 8:10a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jay P. Merkley, M.D. 354	P.O. Box 4064 Pocatello, Idaho 83201	12/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov.19,1969	Mountainview Cemetery,	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 11 1969	Gloria Dopita	Theron Smillie	E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5046
Local Reg. No. 321
Reg. Dist. No. 518

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 784 Cypress Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SAMUEL	JEROME	WILSON	November 16 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	March 3 1912	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Conductor 10	Union Pacific R.R.	Pocatello	Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James . Wilson		Jessie Smith	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	1929 - 1933	712-05-1660	Vera Wilson	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1630 Ca of Pleura — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 Nov, 1968, *to* Nov. 16, 1969, *that I last saw the deceased alive on* Nov. 16, 1969, *and that death occurred at* 8:30a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Pocatello, Idaho	Nov. 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 18, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 20 1969	[signature]	[signature]	E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

NOV 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 3 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 1 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5047
Local Reg. No. 362
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
NOV 26 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 440 Washington Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALMIRA		ALLEN	Nov. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	married	Aug. 9, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Plain City, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Orson C. Raymond		Ann Eliza Rawson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Willard F. Allen	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1890

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Renal Carcinoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Extensive Metastases
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from _____, 1962 to Nov, 1969, that I last saw the deceased alive on Nov 14, 1969, and that death occurred at 6 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	107 N 5th Pocatello	11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov.21,1969	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 25 1969	Gloria Ogilvie	Trevor Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 26 1969
NOV 20 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5048
Local Reg. No. 372
Reg. Dist. No. 519

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03 DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 516 N. 9th

d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Anthony Community Hospital 014

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LAWRENCE		PATTERSON	Nov. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	April 28, 1908	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Ranching	Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George V. Patterson	Texas	Mary Peterson	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	516-36-4908HA	Helen Patterson	Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). 493X

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Anoxia	60 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Asthma - severe	4 years
DUE TO (c)	Allergies	10 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic Heart Disease	12 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 19, 1967, *to* Nov 17, 1969, *that I last saw the deceased alive on* Nov 17, 1969, *and that death occurred at* 9:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard E. Ostler MD	240 N. 18th Pocatello, Idaho	12-1-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov. 20, 69	Lima Cem.	Lima, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 2 1969	Gloria Dopeta	John P. Downard	E-292

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Downard Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5049
Local Reg. No. 363
Reg. Dist. No. 510

RECEIVED DEC 1 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION 019: St. Anthony Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 558 West Lewis Street

3. NAME OF DECEASED (Type or Print): a. (First) FRED b. (Middle) D. c. (Last) QUINN

4. DATE OF DEATH: (Month) November (Day) 18 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 31, 1898

9. AGE (In years last birthday): 71
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banker 26

10b. KIND OF BUSINESS OR INDUSTRY: Banking

11. BIRTHPLACE (State or foreign country): Pocatello Idaho

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Ponce D. Quinn
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Della Payne
BIRTHPLACE: Fillmore, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 519-12-7082

17. INFORMANT'S OWN SIGNATURE: Catharine B. K. Quinn
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Stomach
INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Sept 1969
19b. MAJOR FINDINGS OF OPERATION: Abdominal carcinomatosis of stomach
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello Bannock Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [illegible], 1969 to Nov. 18, 1969, that I last saw the deceased alive on Nov. 18, 1969, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): [signature]
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Nov. 20, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 21, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: NOV 2 1969
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349
FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 30 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 29 1991

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED DEC 1 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5050
Local Reg. No. 367
Reg. Dist. No. 570

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 336 South Second Avenue

3. NAME OF DECEASED (Type or Print): a. (First) LUCILLE; b. (Middle); c. (Last) ANDERSON

4. DATE OF DEATH: (Month) November (Day) 20 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 23, 1945

9. AGE (In years last birthday): 24
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Frank Johnson
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Florence Calahan
BIRTHPLACE: Pocatello, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Dorothy Harris
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Pulmonary infarction, severe — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Pulmonary embolism, severe

DUE TO (c): 50% body burns with emanciation

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: 50% body burns

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): XX
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home, in basement 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello 13031 Bannock Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-28-69 -8am.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Gas furnace exploded

22. *I hereby certify that I attended the deceased from* Oct. 28, *19* 69, *to* Nov. 20, *19* 69, *that I last saw the deceased alive on* Nov. 20, *19* 69, *and that death occurred at* 12:30 am, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H.K. Staheli, M. D. 493
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Nov. 22, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REGISTRAR: NOV 28 1969
REGISTRAR'S SIGNATURE: Gloria Davies
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 12 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 21 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 24 2010

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 14 2010 +2

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5051
Local Reg. No. 373
Reg. Dist. No. 510

RECEIVED
Bureau of Vital Statistics
DEC 8 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 051
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 051
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1028 North Garfield Avenue

3. NAME OF DECEASED (Type or Print): a. (First) HENRY b. (Middle) C. c. (Last) GREGG

4. DATE OF DEATH (Month) (Day) (Year): November 20 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: June 1, 1886

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boilermaker

10b. KIND OF BUSINESS OR INDUSTRY: Union Pacific R. R.

11. BIRTHPLACE (State or foreign country): Springdale, Arkansas

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Henry Gregg
BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Mattie C. Quillan
BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 712-03-1823

17. INFORMANT'S OWN SIGNATURE: William H. Gregg
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1621 Bronchogenic Carcinoma right lung — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 8, 1969, *to* Nov. 20, 1969, *that I last saw the deceased alive on* Nov. 20, 1969, *and that death occurred at* 11:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. W. McRoberts M.D.

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: Nov. 24, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 24, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: DEC 4 1969

REGISTRAR'S SIGNATURE: Gloria Depew

25. EMBALMER: Jack Henderson

LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 15 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5052
Local Reg. No. 367
Reg. Dist. No. 511

BIRTH NO.

DEC 3 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) NADA	b. (Middle)	c. (Last) WETTENBONE	4. DATE OF DEATH (Month) (Day) (Year) Nov. 21, 1969	
5. SEX Female	6. COLOR OR RACE Indian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH about 1879	9. AGE (In years last birthday) 90 (about) IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown	BIRTHPLACE	14. MOTHER'S MAIDEN NAME unknown	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) xxxx	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Frank Payne	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1820

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Endometrial Carcinoma Futurus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 5-17, 1968, *to* 21 Nov, 1969, *that I last saw the deceased alive on* 21 Nov, 1969, *and that death occurred at* 2:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE 505 D L Wright, M.D. (Degree or title)	23b. ADDRESS 1448 E. Center St. Pocatello Idaho	23c. DATE SIGNED 11-28-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov.25,1969	24c. NAME OF CEMETERY OR CREMATORY Cedars Cemetery	24d. LOCATION (City, town, or county) (State) Fort Hall, Idaho
DATE REC'D BY LOCAL REG. DEC 2 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Leon Manning, Jr.	LICENSE NO. E-337

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5053
Local Reg. No. 381
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
DEC 18 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Anthony Hospital 09

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1134 Yellowstone

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GLEN	ROBERTS	FISHER	Nov. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	married	June 10, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fisher Gas Company 09	gas and oil	Smithfield, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Fisher	England	Rachel Roberts	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXXX	528 34 9621	Glenn Fisher	Pocatello, Idaho

2509

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Diabetes Mellitus	Years
	Arteriosclerotic heart disease	Years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertensive cardio-vascular disease	Years
DUE TO (c)	Uremia	Years / Days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* February, 19 58 *to* Nov. 23, 1969, *that I last saw the deceased alive on* Nov. 23, 1969, *and that death occurred at* 4:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arch Wigle, M. D.	1605 N. Arthur Pocatello, Idaho	12-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov. 26, 1969	Smithfield Cemetery	Smithfield, Cache, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 16 1969	Gloria Dopita	Theron Miller	E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5054
Local Reg. No. 365
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031 DEC 1 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello Bureau of Vital Statistics	c. LENGTH OF [illegible] (In this place) b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Community Hospital 019	d. STREET ADDRESS (If rural, give location) 1745 No. Main

3. NAME OF DECEASED (Type or Print) a. (First) Pearl	b. (Middle)	c. (Last) Ortiz	4. DATE OF DEATH (Month) (Day) (Year) Nov. 23, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 20, 1901	9. AGE (In years last birthday) 68 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Heath	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Cecelia Swan	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-52-9122	17. INFORMANT'S OWN SIGNATURE Mrs. Jess Garcia	ADDRESS Pocatello, Idaho	

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 Jan *, 19*69*, to* Nov 23 *, 19*69*, that I last saw the deceased alive on* Nov 23 *, 19*69*, and that death occurred at* 10:45p *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 113	(Degree or title) MD	23b. ADDRESS 8011 E. Center Pocatello Ida	23c. DATE SIGNED 11-25-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 26-69	24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.	24d. LOCATION (City, town, or county) (State) Pocatello, Idaho
DATE REC'D BY LOCAL REG. NOV 2 0 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER [signature]	LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
DEC 12 1969
Bureau of Vital Statistics

State of Idaho } ss
County of Bannock }

Certificate No.

Date Filed Dec. 1, 1969

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Pearl Ortiz (Name on Original Certificate) who Died (Was Born or Died) on Nov. 23, 1969 (Date of Event)
in Pocatello (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Typing error by the Downard Funeral Home (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name	Pearl Otiz	Pearl Ortiz

Subscribed and sworn to before me this 10th day of December, 1969.

Notary Public, residing at Pocatello, Idaho
My commission expires June 20, 1972
(Seal)

Signed Downard Funeral Home by George E. Knapp
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

241 N. Garfield, Pocatello, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of } ss.
County of }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this day of , 19

Notary Public, residing at
My commission expires
(Seal)

Signed
(Signature of Any Credible Person)

(Street Address, City, State)

DEC 12 1969

STATE OF IDAHO

DEPARTMENT OF PUBLIC HEALTH — BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss. Certificate No.

County of Bannock } Date Filed Dec. 1, 1969

DEC 12 1969

Bureau of Vital Statistics

The undersigned does solemnly swear that the certain facts on the certificate of Death (Birth or Death)

for Pearl Ortiz (Name on Original Certificate) who Died (Was Born or Died) on Nov. 23, 1969 (Date of Event)

in Pocatello (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the

true facts are shown by Typing error by the Downard Funeral Home (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date) are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name	Pearl Ortiz	Pearl Ortiz

Subscribed and sworn to before me this 10th day of December, 1969

Signed Downard Funeral Home

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Notary Public, residing at Pocatello, Idaho

My commission expires June 20, 1972

241 N. Garfield, Pocatello, Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.

County of .....

[This Affidavit MUST Also be Executed. (See Chapter 129, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this ..... day of ..... 19.....

Signed .....

(Signature of Any Credible Person)

Notary Public, residing at .....

My commission expires .....

(Seal)

(Street Address, City, State)

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 3 1969 Bureau of Vital Statistics

State File No. 5055
Local Reg. No. 368
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello — LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000	d. STREET ADDRESS (If rural, give location) Yellowstone Hotel Room 414

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM	b. (Middle) HENRY	c. (Last) SMITH	4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 23,1905	9. AGE (In years last birthday) 64 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Uray, Colorado	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abram Mott Smith	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Marie Woodard	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War II	16. SOCIAL SECURITY NO. 521 10 5817	17. INFORMANT'S OWN SIGNATURE Mrs. David Collins	ADDRESS	

9558

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gun-Shot Wound Cranium — INTERVAL BETWEEN ONSET AND DEATH Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ~~ACCIDENT~~ SUICIDE ~~HOMICIDE~~ 2 (Specify) Suicide	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 31	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13031
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — *, 19*__*, to* — *, 19*__*, that I last saw the deceased* ~~alive~~ dead *on* 11-24-69 *, and that death occurred at* ? *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton John 583 + (Degree or title) Coroner	23b. ADDRESS Bannock Co Ida	23c. DATE SIGNED 12-2-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov.29,1969	24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery	24d. LOCATION (City, town, or county) (State) Pocatello, Idaho
DATE REC'D BY LOCAL REG. DEC 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Theron Miller	LICENSE NO. E-524

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

DEC 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED DEC 1 1 1969 Bureau of Vital Statistics

State File No. 5056
Local Reg. No. 375
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA St. Anthony Hospital 019	d. STREET ADDRESS (If rural, give location): 538 N. 13th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)	
CLIFFORD	O.	DICKERSON	Nov. 25,1969	

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 2, 1908	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Parts Dept. 10	Freightline	California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown Dickerson	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	382-05-6837	Mrs C. O. Dickerson	Pocatello, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c).

"This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

3940

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Rheumatic heart disease and

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) mitral insuffiency. Laceration of dramatic valve

DUE TO (c) adjacent to Starr valve implant

INTERVAL BETWEEN ONSET AND DEATH: chronic

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March , 19 53 *to* Nov. 25, 19 69 *that I last saw the deceased alive on* Nov. 25 19 69 *and that death occurred at* 4:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
077 L. S. Call, M.D. M D	Box 852, Pocatello, Ida.	12/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov.29-69	Mountainview Cem.	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 9 1969	Gloria Doyle	John P. Downard	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 12 1969

FEB 10 1970

FEB 20 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5057
Local Reg. No. 369
Reg. Dist. No. 511

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Bannock 030

b. CITY OR TOWN (If outside corporate limits, write township): Lava Hot Springs

LENGTH OF STAY (in this place): 2 Months

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley View Nursing Home 021

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Franklin 210

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mink Creek

d. STREET ADDRESS (If rural, give location): RFD Route

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	SEAREN	WILLIAM	HANSEN	Nov. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	May 11, 1905	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (Retired) 042	Dairying	Mink Creek, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Johan C. Hansen	Denmark	Ane Kathrine Nielsen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 01 8359	x G. Geraldine Nest	Arlington Heights, Ill.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Glomus Jugulare Tumor — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 19, 1964, *to* 3/31/, 1969, *that I last saw the deceased alive on* 3/31, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leo R. Hawkes 214	M.D.	Preston, Idaho	11/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	November 28	Mink Creek Cemetery	Mink Creek, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 4 1969	Gloria Dopeta	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 25 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5058
Local Reg. No. 370
Reg. Dist. No. 511

BIRTH NO.

DEC 3 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bannock 030	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural McCammon c. LENGTH OF STAY (If not in this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Interstate 15 000	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First): REX	b. (Middle): T.	c. (Last): LARSON	4. DATE OF DEATH (Month) (Day) (Year): Nov. 26, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: Dec. 2, 1947	9. AGE (In years last birthday): 21 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03	10b. KIND OF BUSINESS OR INDUSTRY: Ricks College	11. BIRTHPLACE (State or foreign country): Malad, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Roy D. Larson	BIRTHPLACE: Downey, Idaho	14. MOTHER'S MAIDEN NAME: Myrna Taggart	BIRTHPLACE: Lewiston, Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): XXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Roy D. Larson	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8/69

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Internal Injuries

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Multiple

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: ?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): I 15 1 06	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13030 Bannock Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-26-69 4:10 P m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Car out of Control	

22. *I hereby certify that I attended the deceased from* —, 19__, *to* —, 19__, *that I ~~last~~ saw the deceased ~~date~~ dead on* 11-26-69, 19__, *and that death occurred at* 4:10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton John 583	(Degree or title): Coroner	23b. ADDRESS: Bannock Co. Ida	23c. DATE SIGNED: 12-2-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Nov.29,1969	24c. NAME OF CEMETERY OR CREMATORY: Downey Cemetery	24d. LOCATION (City, town, or county) (State): Downey, Bannock, Idaho
DATE REC'D BY LOCAL REG.: DEC 1969	REGISTRAR'S SIGNATURE: Gloria Dopita	25. EMBALMER: Theron Miller	LICENSE NO.: E-524

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5059
Local Reg. No. 382
Reg. Dist. No. 520

BIRTH NO.

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 014 DOA St. Anthony Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 855 East Cedar

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LOUIS	A.	RYLE	Nov. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	July 3, 1903	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver 27	Trucking	Jeffersonville, Indiana	U.S.A.

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
Clarence Ryle	Mamie Louis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No XXX	518 12 6852	Lettie Ryle Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Apparent Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__, that I last saw the deceased alive on 11-28-69 19__, and that death occurred at 1:00 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton J. Jones M.D. Coroner	Bannock Co. Ida.	12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 1, 1969	Restlawn Mem. Gardens	Pocatello, Bannock, Idaho

DATE ACCEPTED BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 16 1969	Gloria Dopita	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 18 1969

JAN 14 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5060
Local Reg. No. 379
Reg. Dist. No. 511

BIRTH NO.

RECEIVED DEC 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): DELORES
b. (Middle):
c. (Last): RACEHORSE

4. DATE OF DEATH: Nov. 30 1969 (Month) (Day) (Year)

5. SEX: Female

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: July 1, 1930

9. AGE (In years last birthday): 39
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Fort Hall, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Nelson Racehorse
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Maude Pocatello
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: althea Fred
ADDRESS: Ft. Hall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

3032

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Subdural hematoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Chronic alcoholism & other ab-

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: normal sustance ingestion of an unknown type.

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov. 28, 19 69 *to* Nov. 30, 19 69, *that I last saw the deceased alive on* Nov. 30, 19 69, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: L.S.CALL, M.D. (Degree or title): M.D.
23b. ADDRESS: Box 852, Pocatello, Ida.
23c. DATE SIGNED: 12/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Dec. 4, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mission Cem.
24d. LOCATION (City, town, or county) (State): Fort Hall, Idaho

DATE REC'D BY LOCAL REG.: DEC 11 1969
REGISTRAR'S SIGNATURE: Gloria Dosta
25. EMBALMER: George A. Knopp
LICENSE NO.: 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5061
Local Reg. No.
Reg. Dist. No. 552

RECEIVED NOV 7 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY (040) Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Highway 30 N
c. LENGTH OF STAY (in this place) In ambulance
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Dead on arrival (24) at

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Wyoming (51) b. COUNTY Lincoln (035)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cokeville
d. STREET ADDRESS (If rural, give location) Hospital

3. NAME OF DECEASED (Type or Print)
a. (First) Alma b. (Middle) Percy c. (Last) Card

4. DATE OF DEATH (Month) (Day) (Year) Nov. 1 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 30, 1901

9. AGE (In years last birthday) 68
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Sign (21)

10b. KIND OF BUSINESS OR INDUSTRY Painter

11. BIRTHPLACE (State or foreign country) Brigham City, Utah

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Alma Card
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Edith Smith
BIRTHPLACE Brigham City Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 529-03-0685A

17. INFORMANT'S OWN SIGNATURE Mrs. A. P. Card
ADDRESS Cokeville, Wyo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction (4109)
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960 (19___), *to* 1969, 19___, *that I last saw the deceased alive on* Nov. 1, 19 69, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) (458)

23b. ADDRESS Montpelier Idaho

23c. DATE SIGNED 11/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal (3)

24b. DATE Nov. 5, 1969

24c. NAME OF CEMETERY OR CREMATORY Cokeville Cemetery

24d. LOCATION (City, town, or county) Cokeville (State) Wyoming

DATE REC'D BY LOCAL REG. 11/6/69

REGISTRAR'S SIGNATURE Ruby Garlinsky

25. EMBALMER Mike Matthews
LICENSE NO. E 359
FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 22 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED NOV 24 1969 Bureau of Vital Statistics STATE OF IDAHO

State File No. 5062
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bloomington
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jesse	Enos	Haddock	Nov. 11. 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 9. 1899	69				

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Custodian	School	Bloomington, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Haddock	Bloomington Ida	Emma Gaffyer	Sc. Cottonwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	—	519-07-4375	Amelia Haddock	Bloomington Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROSIS
DUE TO (c) ASTHMA

INTERVAL BETWEEN ONSET AND DEATH
(a) 2 hrs
(b) 10 yrs
(c) 20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* Nov, 19 69 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 6:05 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD 458	Bloomington Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 15, 1969	Bloomington Cemetery	Bloomington, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11/19/69	Ruby Gortcinsky	Mike Matthews	E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5063
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Alton Idaho
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Died While Hunting Deer 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
d. STREET ADDRESS (If rural, give location) 218 N. 4th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Bill	Wayne	Jensen	Nov. 16 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept 25 1941	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction Work		Shoshone Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elmer Wayne Jensen	Paris Idaho	Lillie Lewis	Dingle Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes		518-46-0404	Nancy Jensen	Montpelier Ida.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial infarction	unknown
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Thrombosis anterior coronary artery, descending branch	unknown
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [✓] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 17 Nov, 1969, to _____, 19____, *that I last saw the deceased alive on* _____, 19____; *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward S. Fisher 613	M.D.	Pocatello, Idaho	17 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 19 1969	Dingle Cemetery	Dingle Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 18, 1969	Ruby Gortcinsky	Vile Matthews	E359

FIRM NAME Matthews Mortuary

Federal Security Agency
United States Public Health Service FORM DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 5 1969

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 7 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5064
Local Reg. No.
Reg. Dist. No. 552

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Near Montpelier
c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION U.S. 30 N. 6 mi. So. East of Montpelier

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 715 Jefferson

3. NAME OF DECEASED (Type or Print) a. (First) Bert b. (Middle) Everett c. (Last) Williams
4. DATE OF DEATH (Month) Nov. (Day) 18. (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Sept. 20, 1926
9. AGE (In years last birthday) 43
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler
10b. KIND OF BUSINESS OR INDUSTRY Wells Cargo
11. BIRTHPLACE (State or foreign country) Minidoka Ida
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Clinton V. Williams
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Helen Rainey
BIRTHPLACE Annis Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 721-14-0026
17. INFORMANT'S OWN SIGNATURE Everett B. Williams
ADDRESS Montpelier Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) SKULL FRACTURE

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) AUTO
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) HIGHWAY 30
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) MONTPELIER IDAHO
21d. TIME OF INJURY (Month) Nov (Day) 18 (Year) 1969 (Hour) 7 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? AUTO ACCIDENT

22. I hereby certify that I attended the deceased from [illegible], 19 [illegible] to 18 Nov, 19 69, that I last saw the deceased alive on 18 Nov, 19 69, and that death occurred at 7 a m., from the causes and on the date stated above.

23a. SIGNATURE G W Schrope MD (Degree or title)
23b. ADDRESS Montpelier Ida
23c. DATE SIGNED 11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Nov 22 1969
24c. NAME OF CEMETERY OR CREMATORY Pleasant View
24d. LOCATION (City, town, or county) (State) Burley Idaho

DATE REC'D BY LOCAL REG. 11-21-69
REGISTRAR'S SIGNATURE Ruby Gortsema
25. EMBALMER Vile Matheus
LICENSE NO. E359
FIRM NAME Matheus Mortuary

Federal Security Agency
United States Public Health Service FORM DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5065
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED
DEC 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Georgetown Idaho
c. LENGTH OF STAY (If hospital or institution)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Georgetown Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Rae b. (Middle) Bingham c. (Last) Dunford

4. DATE OF DEATH (Month) Nov. (Day) 27 (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Apr. 25, 1891

9. AGE (In years last birthday) 78
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dunford Market

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Tuhaka New Zealand

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Oliver C. Dunford
BIRTHPLACE St. Louis Mo.

14. MOTHER'S MAIDEN NAME Ida Osmond
BIRTHPLACE Bloomington Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO. 122-18-3765

17. INFORMANT'S OWN SIGNATURE Mrs Venice Dunford
ADDRESS Georgetown Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart Attack
INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Died Suddenly early
DUE TO (c) Nov 27, 1969 when got to bathroom

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 2 A.M. in Morning died instantly

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Of Heart Attack.

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Georgetown Bear Lake Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Vile Matthews 583 4 (Degree or title) Coroner

23b. ADDRESS Montpelier Idaho

23c. DATE SIGNED 12-4-1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 11 1969

24c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery

24d. LOCATION (City, town, or county) (State) Georgetown Idaho

DATE REC'D BY LOCAL REG. 12/3/69

REGISTRAR'S SIGNATURE Ruby Gotcinsky

25. EMBALMER Vile Matthews

LICENSE NO. E359

FIRM NAME Matthews Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969
FEB 25 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5066
Local Reg. No. 54
Reg. Dist. No. 130

RECEIVED DEC 11 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Plummer
LENGTH OF STAY (in this place) 17 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Plummer
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Leo	Edgar	Mundell	Nov	7	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	married	Feb. 23, 1908	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) battery shop
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hugo, Colo.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jesse W. Mundell — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Rose Phelps — BIRTHPLACE Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 524-03-6880
17. INFORMANT'S OWN SIGNATURE X Mrs. Leo E. Mundell ADDRESS Plummer, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19___, to ___, 19___, *that I last saw the deceased alive on* DOA, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE B. A. Rapp 428 (Degree or title) M.D.
23b. ADDRESS St. Maries Idaho
23c. DATE SIGNED 12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov 11, 1969
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 8, 1969
REGISTRAR'S SIGNATURE Donna Brown
25. EMBALMER Gerald Browning
LICENSE NO. E 411
FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5067
Local Reg. No. 55
Reg. Dist. No. 130

RECEIVED
DEC 11 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
DURATION OF STAY (in this place) 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Comm. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) 402 12th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Daniel	J.	Curtis	Nov. 12 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	Aug. 24, 1882	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Factory-Varied	Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frederick Curtis	Michigan	Mary Wright	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	368-14-2936	Marian D. Maltby	928 S. Washington Ave. Lansing Mich.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac decompensation

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 8, 1969, *to* Nov 12, 1969, *that I last saw the deceased alive on* Nov 12, 1969, *and that death occurred at* 2:05 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B. A. Rapp 428	M.D	St. Maries, Idaho	12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 15, 1969	Woodlawn	St. Maries Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 8, 1969	Donna Brown	Gerald Browning	E-411

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Browning Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5068
Local Reg. No. 50
Reg. Dist. No. 130

Certificate of Death

RECEIVED
DEC 2 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): PLUMMER
c. LENGTH OF STAY (in this place): Few min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DR. Wm. Morris's Office 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah 050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Maries
d. STREET ADDRESS (If rural, give location): 230 2nd Street

3. NAME OF DECEASED (Type or Print)
a. (First): Leslie
b. (Middle): Laverne
c. (Last): Thomas

4. DATE OF DEATH (Month) (Day) (Year): Nov. 19 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 28 1906
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proprietor 22
10b. KIND OF BUSINESS OR INDUSTRY: Mercantile
11. BIRTHPLACE (State or foreign country): Montana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David A. Thomas — BIRTHPLACE: Mo.
14. MOTHER'S MAIDEN NAME: Lulu E. Haggerty — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 517-09-5997
17. INFORMANT'S OWN SIGNATURE: Matie Thomas — ADDRESS: St Maries Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — Unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Hypertension — Unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 1969, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 11 45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. J. Thurston 533 MD.
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 24 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: Nov. 22 1969
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: Nov. 28, 1969
REGISTRAR'S SIGNATURE: Donna Brown
25. EMBALMER: Gerald Browning — LICENSE NO.: E-411

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5069
Local Reg. No. 51
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 052 — DEC 2 1969 — Bureau of Vital Statistics
b. CITY OR TOWN: St. Maries
c. LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Vista Conv. Center 352

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah 052
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): Valley Vista Conv. Center

3. NAME OF DECEASED (Type or Print): a. (First) Mildred — b. (Middle) (none) — c. (Last) Mellen

4. DATE OF DEATH (Month) (Day) (Year): November 20, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 26, 1901

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.: 67

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Heber City, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-21-9631

17. INFORMANT'S OWN SIGNATURE: Joseph E. Mellen — ADDRESS: St. Maries, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4209

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Arteriosclerosis — Unknown

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetes — Unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: ~~Diabetes~~

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19__, *to* ____, 19__, *that I last saw the deceased alive on* 20 Nov, 1969, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. E. Thurston 535 (Degree or title) MD — **23b. ADDRESS**: St. Maries, Idaho — **23c. DATE SIGNED**: 24 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Nov. 24, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Woodlawn — **24d. LOCATION** (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: Nov. 28, 1969 — **REGISTRAR'S SIGNATURE**: Donna Brown

25. EMBALMER: Gerald Browning — **LICENSE NO.**: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 2 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5070
Local Reg. No. 52
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah 052
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley Vista Conv Center 352

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah 052
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) Rt 2

3. NAME OF DECEASED (Type or Print) a. (First) Alonzo b. (Middle) MARK c. (Last) MARTIN

4. DATE OF DEATH (Month) (Day) (Year) Nov. 21 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Dec. 4 1908
9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) Non
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Jack A Martin ADDRESS St. Maries

4709

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 15 m

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19___, to ___, 19___, *that I last saw the deceased alive on* 20 Nov, 1969, *and that death occurred at* 6A m., *from the causes and on the date stated above.*

23a. SIGNATURE W. D. Thurston (Degree or title) MD 533
23b. ADDRESS St. Maries, Idaho
23c. DATE SIGNED 24 Nov 69

24a. BURIAL, CREMATION, REMOVAL, (Specify) Burial
24b. DATE Nov 25, 1969
24c. NAME OF CEMETERY OR CREMATORY Woodlawn
24d. LOCATION (City, town, or county) (State) St. Maries, Idaho

DATE REC'D BY LOCAL REG. Nov. 28, 1969
REGISTRAR'S SIGNATURE Donna Brown
25. EMBALMER Jerry Browning
LICENSE NO. E-411
FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dortes

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5071
Local Reg. No. 161
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061 DEC 8 1969

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot Bureau of Vital Statistics

c. LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 061

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) LEON b. (Middle) BRYAN c. (Last) SIMS

4. DATE OF DEATH (Month) (Day) (Year) October 21, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH January 17, 1897

9. AGE (In years last birthday) 72 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 10

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (State or foreign country) Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME Charles F. Sims BIRTHPLACE California

14. MOTHER'S MAIDEN NAME Phoebe Molter BIRTHPLACE Huntington, Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs Earl Hansen ADDRESS Firth, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fract Hip
DUE TO (c) Diabetes

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1955, 19__, *to* October 21, 19 69, *that I last saw the deceased alive on* October 21, 19 69, *and that death occurred at* 5:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE Ralph G. Goates 183 (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED Oct 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Oct 24, 1969

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) Blackfoot (State) Idaho

DATE REC'D BY LOCAL REG. DEC 3 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER C. Dean Hill LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5072
Local Reg. No. 152
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: California 05
b. COUNTY: San Francisco 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Daly City
d. STREET ADDRESS (If rural, give location): 231 Los Olivas Ave.

3. NAME OF DECEASED (Type or Print): a. (First) ARTHUR b. (Middle) c. (Last) HEYDEN

4. DATE OF DEATH: (Month) November (Day) 1, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: December 13, 1902

9. AGE (In years last birthday): 66
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 06

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Berlin, Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 546-10-0303

17. INFORMANT'S OWN SIGNATURE: Agatha Blenkle
ADDRESS: San Francisco, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 185X Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastatic — 8mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 4 1969 *to* _____, 19____, *that I last saw the deceased alive on* Nov. 6, 1969, *and that death occurred at* 8:30a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O. M. Withers M.D. 569

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Nov 3, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Nov 4, 1969

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: NOV 5 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: C. Deanfell

LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 14 1969

NOV 26 1969

JAN 28 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5073
Local Reg. No. 153
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 700 Curtis St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 700 Curtis St.

3. NAME OF DECEASED (Type or Print) a. (First) RUTH b. (Middle) ANN c. (Last) JENSEN YOST

4. DATE OF DEATH (Month) (Day) (Year) November 1, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH March 6, 1908

9. AGE (In years last birthday) 61
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY Education

11. BIRTHPLACE (State or foreign country) Marquette, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hans F. Jensen
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Karan Marie Nielson
BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-28-3470

17. INFORMANT'S OWN SIGNATURE Linda Rae Yost
ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4519

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH: ONE Hour

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) THROMBOPHLEBITIS PELVIC VEINS — 5 DAYS
DUE TO (c) RESECTION SIGMOID COLON — 2 WEEKS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* November 1, 19 69, *that I last saw the deceased alive on* November 1, 19 69, *and that death occurred at* 12:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE Gary K. Haddock (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED Nov 5, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Nov 5, 1969

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) Blackfoot (State) Idaho

DATE REC'D BY LOCAL REG. NOV 6 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 14 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5076
Local Reg. No. 150
Reg. Dist. No. 601

BIRTH NO.

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley, R#1
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley,
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Albert	William	Clinger	Nov	2	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cac	Married	Oct 18 1899	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: of
11. BIRTHPLACE (State or foreign country): Lakeview, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John William	Lakeview, Utah	Josepha Zobell	Provo, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3 2001	519-12-5259	John W. Clinger	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Lymphosarcoma — (Interval between onset and death: 11 mo)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8-8- , 1968 , to 11-2- , 1969 , that I last saw the deceased alive on 12 June , 1969 , and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 294	Idaho Falls, Idaho 83401	10 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov 5, 1969	Fielding Memorial	Idaho Falls, Bonneville Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 13, 1969	Dorothy J. Jones	[signature]	E 275

FIRM NAME: Fielding Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 17 1969
JAN 5 1970
MAY 2 9 1996

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 5075
Local Reg. No. 158
Reg. Dist. No. 600

BIRTH NO. DEC 3 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Blackfoot
d. STREET ADDRESS (If rural, give location) Rockford

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Ancle c. (Last) Peterson

4. DATE OF DEATH (Month) (Day) (Year) Nov. 6, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Dec. 18, 1890

9. AGE (In years last birthday) 78
IF UNDER 1 YR. Months 10 Days 29
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant 22

10b. KIND OF BUSINESS OR INDUSTRY Groc. & Dry Goods

11. BIRTHPLACE (State or foreign country) Elsinore, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hans Peterson BIRTHPLACE Standby, Denmark

14. MOTHER'S MAIDEN NAME Sarah Alice Christensen BIRTHPLACE Elsinore, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-38-5913A

17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Rockford, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5699

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gastrointestanal Bleeding — INTERVAL BETWEEN ONSET AND DEATH 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility Severe — 3 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr, 1969, *to* Nov 6, 1969, *that I last saw the deceased alive on* Nov. 7, 1969, *and that death occurred at* 8:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) M.D.

23b. ADDRESS 625 West Pacific Blackfoot, Idaho

23c. DATE SIGNED 11-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-10-69

24c. NAME OF CEMETERY OR CREMATORY Riverside- Thomas Cem.

24d. LOCATION (City, town, or county) (State) Route #5, Blackfoot, Idaho

DATE REC'D BY LOCAL REG. DEC 1 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Howard Packham

LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

MAR 20 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 5076
Local Reg. No. 157
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: BINGHAM 661 NOV 24 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: MADISON 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot, Idaho — Bureau of Vital Statistics — c. LENGTH OF STAY (If in hospital or place): 5 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): STATE HOSPITAL SOUTH 033	d. STREET ADDRESS (If rural, give location): 246 South First West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
REED	P.	COOK	11	7	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	1-19-1926	43		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Car Salesman 24		Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles R. Cook	Idaho	Hazel Phillips	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-46-9527	Ruth S. Hopkins	Medical Records - State Hospital South

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardio-Respiratory Failure	6 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Atrial Fibrillation	
DUE TO (c)	Congestive Heart Failure	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 3, 1969, *to* November 7, 1969, *that I last saw the deceased alive on* November 7, 1969, *and that death occurred at* 10.a. *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Magrose 594 M.P.		State Hospital South Blackfoot, Idaho	11-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3 Burial	11/10/69 11-7-69	Rexburg Cemetery	Rexburg, Madison, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 20 1969	Dorothy J. Jones	Russel Flamm	E-254

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: FLAMM MORTUARY - Rexburg

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5077
Local Reg. No. 137
Reg. Dist. No. 6-1

RECEIVED NOV 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield (Rural)
c. LENGTH OF STAY (In this place): minutes
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 389 No. Capital St.

3. NAME OF DECEASED (Type or Print) a. (First): MEDARDO b. (Middle): c. (Last): RODRIGUEZ
4. DATE OF DEATH (Month) (Day) (Year): November 7, 1969

5. SEX: male
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH: Aug 15, 1920
9. AGE (In years last birthday): 49
IF UNDER 1 YR. Months | Days:
IF UNDER 24 HRS. Hours | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Leucio, New Mexico
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Rodriguez BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII 4
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT'S OWN SIGNATURE: ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 9229 Shot in head — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): 30-30 Cal. rifle
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): / accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 31
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13060
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from xxx November 7, 1969 xxxx

NOV 2 5 1969

JAN 1 7 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 1 4 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5078
Local Reg. No. 155
Reg. Dist. No. 600

BIRTH NO.

RECEIVED NOV 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bingham 061	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot	c. LENGTH OF TOWN (In this place) 1 day
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029	d. STREET ADDRESS (If rural, give location) Route 3

3. NAME OF DECEASED (Type or Print) a. (First) LAURA	b. (Middle) MELVINA	c. (Last) SABIN	4. DATE OF DEATH (Month) (Day) (Year) November 8, 1969	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH October 23, 1900	9. AGE (In years last birthday) 69 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Ucon, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Yancey	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Rosa Fowers	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Mae Orr	ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hypertention → CVA — INTERVAL BETWEEN ONSET AND DEATH: Several months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1966 *to* November 8, 1969, *that I last saw the deceased alive on* November 8, 1969, *and that death occurred at* 11:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) M.D.	23b. ADDRESS Blackfoot Idaho	23c. DATE SIGNED Nov 11,69	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Nov 12,1969	24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	24d. LOCATION (City, town, or county) Shelley (State) Idaho
DATE REC'D BY LOCAL REG. Nov. 14, 1969	REGISTRAR'S SIGNATURE Dorothy J. Jones	25. EMBALMER [signature]	LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5079
Local Reg. No. 159
Reg. Dist. No. 600

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061 DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 602

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) "JACK" c. (Last) HOLBROOK

4. DATE OF DEATH (Month) (Day) (Year) Nov. 14, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Feb. 26, 1920

9. AGE (In years last birthday) 49
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction //

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Salmon, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Clyde Holbrook
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Mable Taysom
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II

16. SOCIAL SECURITY NO. 518 32 4419

17. INFORMANT'S OWN SIGNATURE Thelma Girard ADDRESS Inkom, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 486 Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) Blackfoot (COUNTY) Bingham (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Did not see alive, 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE Earl Staley 583 (Degree or title)

23b. ADDRESS 321 E Walker Blackfoot

23c. DATE SIGNED 11-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE Nov. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY Inkom Cemetery

24d. LOCATION (City, town, or county) (State) Inkom, Bannock, Idaho

DATE REC'D BY LOCAL REG. 26 Nov. 69

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Theron Miller

LICENSE NO. E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

State File No. 5080
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BINGHAM
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot, Idaho
DURATION OF STAY (In this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 633

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOSEPH	H.	TAYLOR	11	14	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	1-1-1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 28		Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hedidiah Taylor	Unknown	Katherine Woolsey	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Unknown	540-16-987 3A	Ruth S. Stephens	Medical Records, State Hospital South

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	486 X Congestive Heart Failure	24 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pleural Effusion	7 Days
DUE TO (c)	Pneumonia	48 Hours
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* October 17, 19 69, *to* November 14, 19 69, *that I last saw the deceased alive on* November 14, 19 69, *and that death occurred at* 6:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward C. Jr. 394 M.D.	State Hospital South Blackfoot, Idaho	11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 93	11/19/69	Star Cemetery	Star Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 20 1969	Dorothy J. Jones	PACKHAM MORTUARY	E-338

FIRM NAME: Howard Packham

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5081
Local Reg. No. 165
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
DEC 8 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Blackfoot
c. LENGTH OF STAY (In this place):
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 190 South Stout St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LESTER	E.	WINSCHELL	November 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	January 21, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stockman 04	Livestock	Sterritt, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Winschell		Dora Cates	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes W.W. I 3	519-40-8916	Keith W. Winschell	Blackfoot, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac Decompensation 4109	3 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary artery disease	?
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus	10 yrs ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 19 68, 19___, *to* Nov 14, 19 69, *that I last saw the deceased alive on* Nov 14, 19 69, *and that death occurred at* 1:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Blackfoot, Idaho	Nov 17, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov 17, 1969	Grove City Cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 3 1969	Dorothy L. Jones	L. Dean Hill	E-466

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

DEC 9 1969
DEC 18 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably), accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5082
Local Reg. No. 163
Reg. Dist. No. 600

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 06 Bingham DEC 8 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 06

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot

c. LENGTH OF STAY (In this place) 4 years

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

d. STREET ADDRESS (If rural, give location) North East Main St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRANK	B.	SILENE	November 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	divorced	November 5, 1917	51		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		Blackfoot, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Silene	Dakota	Leonore Biethan	Blackfoot, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes W.W.II +	518-14-9842	Diana L. Silene	Reading, Mass.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4867 Pneumonia — Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [XX] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from November 15, 19 69 and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl Stone 583	Coroner	Blackfoot Idaho	Nov 20, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3	Nov 20, 1969	Hillcrest Cemetery	Arco Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 3 1969	Dorothy J. Jones	L. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5083
Local Reg. No. 164
Reg. Dist. No. 606

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moreland
LENGTH OF STAY (In this place): 60 years
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moreland
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	HENRY	HAMMOND	November 16, 1889

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	January 31, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 64	Agriculture	Mancos, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel S. Hammond	Hawaii	Elnora Sorensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-10-8661		Moreland, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary heart disease with decompensation. — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19 50, *to* November 16, 19 69, *that I last saw the deceased alive on* November 16, 19 69, *and that death occurred at* 4:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	Blackfoot, Idaho	Nov 20, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov 19, 1969	Moreland cemetery	Bingham county, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 3 1969	Dorothy J. Jones	L. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 9 1969
FEB 11 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5084
Local Reg. No. 163
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham county nursing home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall (Rural)
d. STREET ADDRESS (If rural, give location) Fort Hall reservation

3. NAME OF DECEASED (Type or Print) a. (First) WILLIE b. (Middle) TOMMY c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) November 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	Indian	widowed	1891	32		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer		unknown	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Major Tommy	unknown	Yambanzie	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Dan Snipe	Fort Hall, Idaho

4124

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9 June, 1969, to Nov 21, 1969, that I last saw the deceased alive on Nov 21, 1969, and that death occurred at 11:33p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Walter W Hoge 234	M.D.	Blackfoot, Idaho	Nov 25, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov 24, 1969	Gibson cemetery	Fort Hall reservation, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 3 1969	Dorothy J Jones	L. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED IDAHO

State File No. 5085
Local Reg. No. 160
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: 061 Bingham — DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY IN THIS PLACE: 54 days

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: California 05 — b. COUNTY: 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena
d. STREET ADDRESS (If rural, give location):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Nursing Home 029

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Amelia	Rogers	Nov.	22,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed	May 7, 1879	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	own home	Logan, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter John Fjelsted	Denmark	Bertha Marie Jensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none 501-34-5088	Lauren L Fjelsted	Blf't., Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Viral Pneumonia	48h
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept. 19 69, *to* November 19 69, *that I last saw the deceased alive on* Nov. 22, 19 69, *and that death occurred at* 10:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	Blackfoot, Idaho	11-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	25. EMBALMER	LICENSE NO.
Burial	11-25-69	Riverside-Thomas Cem.	Blackfoot, Rt. #5, Idaho	Howard Packham	E-338

DATE REC'D BY LOCAL REG.: DEC 1 1969
REGISTRAR'S SIGNATURE: Timothy J. Jones

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Howard Packham Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 8 1969 Bureau of Vital Statistics

State File No. 5086
Local Reg. No. 166
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bingham 060	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho 13 b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall (Rural)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall (Rural)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fort Hall Reservation 000	d. STREET ADDRESS (If rural, give location) Ferry Butte Road

3. NAME OF DECEASED (Type or Print)	a. (First) JAMES	b. (Middle) LAURIN	c. (Last) TONE SR.	4. DATE OF DEATH (Month) (Day) (Year) November 22, 1969
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 13, 1937	9. AGE (In years last birthday) 32 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Fort Hall, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charley Tone	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Ruby Bigman	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 544-40-7646	17. INFORMANT'S OWN SIGNATURE	ADDRESS Fort Hall, Idaho

955X

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Shot in head — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Self inflicted gun shot

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 2 Suicide	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 31	21c. (CITY, TOWN, OR TOWNSHIP) 12 miles SW Blackfoot 13060	(COUNTY) Bingham (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased* ~~from~~ November 22, 1969, ~~[illegible]~~ ~~[illegible]~~, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Carl Stoby 583	(Degree or title) 4 Coroner	23b. ADDRESS Blackfoot, Idaho	23c. DATE SIGNED Nov 25, 1969
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Nov 28, 1969	24c. NAME OF CEMETERY OR CREMATORY Gibson Cemetery	24d. LOCATION (City, town, or county) (State) Fort Hall Reservation, Idaho
DATE REC'D BY LOCAL REG. DEC 3 1969	REGISTRAR'S SIGNATURE Dorothy J. Jones	25. EMBALMER C. Dean Hill	LICENSE NO. E-466

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

SEP 2 9 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5087
Local Reg. No. 22
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED
DEC 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
c. LENGTH OF STAY (If outside this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NORMA	AGNES	HORSCH	Nov. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Married	April 18, 1920	49	7	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Rockford, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jens Jensen	Denmark	Ane Kristina Jensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-38-6097	Wally Horsch	Aberdeen, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Metastatis adenocarcinoma of lung	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Atelectasis lower right lobe of lung	4 mo.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-23-68, 19____, *to* 11-26-69, 19____, *that I last saw the deceased alive on* 11-3-69, 19____, *and that death occurred at* 7:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E L Harris 203	M D	213 Idaho St. American Falls, Idaho	12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	12-1-69	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-9-69	Irene Deeg	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 30 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 17 1981

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5088
Local Reg. No. 169
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
LENGTH OF STAY (In this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 459 East Judicial St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 459 East Judicial St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DELLA	MAXINE	WADSWORTH	November 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	Indian	married	June 16, 1928	41		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Practical nurse 13	Medical	Fort Hall, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Moss	Plains, Montana	Elsie Truchot	Cheotau, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. II	518-38-8993	Della M Wadsworth	Blackfoot, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Convulsive disorder, cause unknown	15 minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12 Sept. 1955 *to* November 27, 1969 *that I last saw the deceased alive on* November 27, 1969 *and that death occurred at* 9:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Walter G Hoge 234	M.D.	Blackfoot, Idaho	Dec 1, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
burial	Dec 2, 1969	Grove City Cemetery	Blackfoot	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 3 1969	Dorothy Jones	L. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

FEB 26 1970

MAR 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 6 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. AUG 19 1970
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5089
Local Reg. No. 38
Reg. Dist. No. 410

BIRTH NO.

NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 070 Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sun Valley, Idaho
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ketchum
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Florence
b. (Middle) Marrie
c. (Last) Law

4. DATE OF DEATH (Month) (Day) (Year) Nov. 1, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 22, 1899

9. AGE (In years last birthday) 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec. 19

10b. KIND OF BUSINESS OR INDUSTRY Motel

11. BIRTHPLACE (State or foreign country) New York, New York

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME William H. Reilly
BIRTHPLACE New York, N Y

14. MOTHER'S MAIDEN NAME Ann Garwin
BIRTHPLACE New York, N.Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 712-03-1677

17. INFORMANT'S OWN SIGNATURE Billie G. Law
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

174X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF BREAST — INTERVAL BETWEEN ONSET AND DEATH 7 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* YEARS, 19___, *to* 1 NOV, 1969, *that I last saw the deceased alive on* 1 NOV, 1969, *and that death occurred at* 10 a m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD

23b. ADDRESS Sun Valley Idaho

23c. DATE SIGNED 11/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 5, 1969

24c. NAME OF CEMETERY OR CREMATORY Ketchum Cemetery

24d. LOCATION (City, town, or county) Ketchum (State) Idaho

DATE REC'D BY LOCAL REG. Nov-14-69

REGISTRAR'S SIGNATURE Robert N. Wright by per BW

25. EMBALMER Keith Bird [signature]

LICENSE NO. E-373

FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended
Nov. 17, 1970

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5090
Local Reg. No. 37
Reg. Dist. No. 410

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 070 NOV 17 1969 — Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Sun Valley, Idaho | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE — Idaho
b. COUNTY — Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Ketchum
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Elbert	Newton	Sexton	Nov.	1	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	July 12, 1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		Sturgeon, Missouri	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William K. Sexton,	Ky.	Cora Hutchinson	Ky.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W W I 3	518-14-0090	X Amy B. Sexton	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia, Bronchial	24 hrs+
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Carcinoma of Liver	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-31, 1969, *to* 11-1, 1969, *that I last saw the deceased alive on* 11-1, 1969, *and that death occurred at* 12:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
374 John R. Mowry MD	Sun Valley Idaho	11-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 5, 1969	Ketchum Cemetery	Ketchum, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 14 69	Robert H. Wright	Keith Bird	E-373

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bird Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
NOV 16 1970
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. 69-5090

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Elbert Newton Sexton (Name on Original Certificate) who died (Was Born or Died) on Nov 1, 1969 (Date of Event)
in Sun Valley, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Census record (Bible Record, Insurance Policy, Etc.) prepared on 1942 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#11 Birthplace	Sturgeon, Montana	Sturgeon, Missouri

Subscribed and sworn to before me this 5th day of November, 1970

Notary Public, residing at Hailey Idaho
My commission expires Mar 14, 1974
(Seal)

Signed Amy D. Sexton
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of IDAHO } ss.
County of BLAINE }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 6th day of November, 1970

Notary Public, residing at Hailey, Idaho
My commission expires Mar. 14, 1974
(Seal)

Signed Ruth Bird
(Signature of Any Credible Person)

403 N. Main Hailey, Idaho
(Street Address, City, State)

FORM DH 60-155

MAY 4 1971

JAN 14 1982

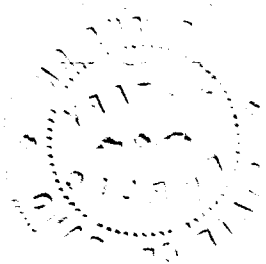

Certificate of Death

STATE OF IDAHO

State File No. 5091
Local Reg. No. 39
Reg. Dist. No. 410

BIRTH NO.

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Blaine 010

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley

c. LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Camas 130

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield

d. STREET ADDRESS (If rural, give location): P.O. Box # 34

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Clysta	Cloe	Moon	Nov. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Mar. 7, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Fairview, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henderson Cox	Union Fork, Utah	Annie C. Peterson---Mtn. Pleasant,	Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-------	519-44-9802-A	Mrs. William Moore	Hagerman, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

284X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pancytopenia - etiology unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6 , 19 69 to 11/9 , 19 69, *that I last saw the deceased alive on* 11/9 , 19 69 *and that death occurred at* 12:35 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Sun Valley Idaho	11/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov. 12, 1969	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	EMBALMER	LICENSE NO.
Nov-19-69	Robert H. Wright for C.B.W.	Eddie E. Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 1 1969

DUTIES:

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 8 1969 Bureau of Vital Statistics

State File No. 5092
Local Reg. No. 332
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boise
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pine Top, near Idaho City
c. LENGTH OF STAY (In this place) few hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pine Top, near Idaho City

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1709 Merrill St.

3. NAME OF DECEASED (Type or Print) a. (First) BRIAN b. (Middle) DOUGLAS c. (Last) HODGES

4. DATE OF DEATH (Month) (Day) (Year) July 26, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) never married

8. DATE OF BIRTH Sept. 20, 1962

9. AGE (In years last birthday) 6
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Boise

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME BIRTHPLACE James Dale Hodges, Franklin, Idaho

14. MOTHER'S MAIDEN NAME BIRTHPLACE Mary Darlene Sexton, Chinook, Montana, Blaine County

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Axphyxiation by drowning

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE Accident (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 18

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13080

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 583 (Degree or title) Boise Co. Coroner

23b. ADDRESS Star Route Banks, Idaho

23c. DATE SIGNED 10-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE July 29, 1969

24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens

24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. 12/4/69

REGISTRAR'S SIGNATURE Henrietta Penrod

25. EMBALMER Conway Grant

LICENSE NO. E 478

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5093
Local Reg. No. 332
Reg. Dist. No. _____

BIRTH NO.

RECEIVED
DEC 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boise 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Banks
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): One Mile North of Banks 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Boise 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 7701 Ustick Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WAYNE	LYLE	ARCHER	Nov. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	8-19-1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FOREMAN 08	City St. Dept.	Alberta, Canada	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Carnagey	no record	Gladys Anderson	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Peacetime 8169	556 09 4198	X Lois Archer	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Severe Head & Brain Injury.	Mins;
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Left Rib punctures.	
DUE TO (c)	Both Hips Broken.	Mins;
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	06	13080

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		Icy Road. lost Control of Auto. went into River.

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at 830Am. m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise.	11-21-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial - 3	11-19-1969	Cloverdale Cemetery	Boise	Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/5/69	Henrietta Tennant	[signature]	E527

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

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DEC 9 1969
DEC 19 1969
JAN 8 1970
MAR 7 1989
MAY 21 1993

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ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics
DEC 8 1969

State File No. 5094
Local Reg. No. 352
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boise 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) --
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 1 mi. E. of Banks

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Boise 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Horseshoe Bend
d. STREET ADDRESS (If rural, give location) Box 169

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jimmie	Wayne	Savola (King)	Nov. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Oct. 20, 1947	22	0 / 25	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 17	lumber	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wayne Savola	Phelps, Wisconsin	Lois Delores Moss	Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	538-44-0783	X Sharon King	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiple Fracture Head & Chest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 130 80

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard T. Hawley	583 4 Boise Co. Coronor	Star Rt. Banks, Idaho	11-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Reburial 3	Nov. 17, 1969	Medford	Medford, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-4-69	Henrietta Penrod	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 15 1970

JUN 14 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5095
Local Reg. No. #117
Reg. Dist. No.

BIRTH NO.

RECEIVED DEC 15 1969 Vital Statistics Bureau of

1. PLACE OF DEATH

a. COUNTY 09 Bonner

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint

c. LENGTH OF STAY (in this place) 1 1/2 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY Bonner 09

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint

d. STREET ADDRESS (If rural, give location) 922 Cedar

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Andrew	Walton	Swaney	October 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 30, 1899	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printer 21	Printing	Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hugh G. Swaney	No record	Marion Pettibone	No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WWI 3	533 01 7145 A	Lillian P Swaney	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arterio sclerosis — 10 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 10, 1968, *to* 10-20, 1969, *that I last saw the deceased alive on* 10-20, 1969, *and that death occurred at* 11:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred E. Mauerman 327 MD	Sandpoint Idaho	12-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct 20, 1969		

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/12/69	Dale Coffelt	Dale Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 24 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5096
Local Reg. No. #101
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 041
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 059

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fernwood
d. STREET ADDRESS (If rural, give location): General Delivery

3. NAME OF DECEASED (Type or Print): a. (First) Peter b. (Middle) H. c. (Last) Hansen

4. DATE OF DEATH (Month) (Day) (Year): October 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 12, 1890

9. AGE (In years last birthday): 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: No record — BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 533 01 9592 A

17. INFORMANT'S OWN SIGNATURE: Mrs. Myron Cady for Clara Hansen — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) cerebrovascular accident — 12 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. emphysema — 10 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-7-67, 19__, *to* 10-21-, 1969, *that I last saw the deceased alive on* 10 20, 1969, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 327 (Degree or title): MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 11-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3
24b. DATE: Oct 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: St. Maries Cemetery
24d. LOCATION (City, town, or county) (State): St. Maries, Idaho

DATE REC'D BY LOCAL REG.: 11/21/69
REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501
FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

MAR 9 1971

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 5097
Local Reg. No. #102
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bonner 040 NOV 17 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Priest River Bureau of Vital Statistics; c. LENGTH OF DEATH (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jack Pine Flats 000	d. STREET ADDRESS (If rural, give location): Rt. 2 Box 42-A

3. NAME OF DECEASED (Type or Print)	a. (First) Ernest	b. (Middle) Edward	c. (Last) Brennecke	4. DATE OF DEATH (Month) (Day) (Year) Nov 1 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 2/20/1895	9. AGE (In years last birthday): 74; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY: Diversified	11. BIRTHPLACE (State or foreign country): Wisconsin	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Otto Brennecke	BIRTHPLACE: Wisconsin	14. MOTHER'S MAIDEN NAME: Barbara Renz	BIRTHPLACE: Unobtainable	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes; (If yes, give war or dates of service): WW I 3	16. SOCIAL SECURITY NO.: None	17. INFORMANT'S OWN SIGNATURE: Otto Brennecke	ADDRESS: Rt 2 Box 42-A Post Falls Id.	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Occlusion	30 minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary Heart Disease	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Barry D. Nelson 583 4 (Degree or title) Coroner	23b. ADDRESS: Box 475 Sandpoint	23c. DATE SIGNED: 11/10/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 11/1/69	24c. NAME OF CEMETERY OR CREMATORY: Sherman Funeral Home	24d. LOCATION (City, town, or county) (State): Newport, Wash. 99156
DATE REC'D BY LOCAL REG.: 11/13/69	REGISTRAR'S SIGNATURE: Dale Pedersen	25. EMBALMER: N. F. Riplinger, Jr.	LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 5098
Local Reg. No. 1708
Reg. Dist. No.

STATE OF IDAHO

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonner 041
b. CITY OR TOWN: Sandpoint
c. LENGTH OF STAY in this place: hours

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Pend Oreille 033
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Newport
d. STREET ADDRESS (If rural, give location): Route 2, Box 228

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thomas	Martin	Craig	November 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Sept. 21, 1879	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Own farm	California	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas P. Craig	no record	Mary N. Osborn	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 05 2362 A	Lester Craig	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Congestive Heart Failure	1-2 Hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Emphysema and Arteriosclerotic	years
DUE TO (c)	Heart Disease	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug, 1969, *to* Nov 1, 1969, *that I last saw the deceased alive on* Nov 1, 1969, *and that death occurred at* 2 3/4 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Sandpoint Idaho	11/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 4, 1969	Pinecrest Memorial Park	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11/10/69	[signature]	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5099
Local Reg. No. #106
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Route 1, Box 450

3. NAME OF DECEASED (Type or Print)
a. (First): Earl
b. (Middle): Robert
c. (Last): Davis Sr.

4. DATE OF DEATH (Month) (Day) (Year): November 1, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 28, 1901
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert H. Davis — BIRTHPLACE: Oregon
14. MOTHER'S MAIDEN NAME: Mrs. Vallie R. Davis (Earl R) — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -------
16. SOCIAL SECURITY NO.: 539 05 6396
17. INFORMANT'S OWN SIGNATURE: Mary E. McNearney — ADDRESS: Iowa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

885X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): HEAD INJURY c̄ Cerebral — INTERVAL BETWEEN ONSET AND DEATH: 4 day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Edema and possible
DUE TO (c): Cerebral Hemorrhage — 1 day

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 10/29/69
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): FARM 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Sandpoint Idaho Bonner 13090

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10 29 69 m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Patient fell and hit Head on Rock

22. *I hereby certify that I attended the deceased from* 10/29, 1969, *to* 11/1, 1969, *that I last saw the deceased alive on* 10/29/69, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 471 (Degree or title): MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 11/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pack River Cemetery
24d. LOCATION (City, town, or county) (State): Bonner County Idaho

DATE REC'D BY LOCAL REG.: 11/21/69
REGISTRAR'S SIGNATURE: Dale Pederson
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5100
Local Reg. No. #103
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 090
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Edgemere
c. LENGTH OF STAY (in this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 miles east of Edgemere 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Athol
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Elgie b. (Middle) Orlo c. (Last) Skellenger

4. DATE OF DEATH (Month) (Day) (Year): November 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 10, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Wesley Skellenger — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Rose Anna Dodd — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -------
16. SOCIAL SECURITY NO.: 519 10 4305
17. INFORMANT'S OWN SIGNATURE: Robert E. McCray — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Barry D. Nelson (Degree or title) 583 + Coroner
23b. ADDRESS: Box 475 Sandpoint
23c. DATE SIGNED: 11/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Memorial Park
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 11/21/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: L. G. Moon, Jr. — LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5101
Local Reg. No. #110
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 26 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 091 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (In this place): 6 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Clackamas 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Estacada
d. STREET ADDRESS (If rural, give location): Route 1, Box 244

3. NAME OF DECEASED (Type or Print)
a. (First): Nina
b. (Middle): Grace
c. (Last): Callen

4. DATE OF DEATH (Month) (Day) (Year): November 4, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 6, 1887
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas E. Donnals — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Anna McNeely — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 540 60 3206J1
17. INFORMANT'S OWN SIGNATURE: Bessie Sanner — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1969, *to* Nov 4, 1969, *that I last saw the deceased alive on* Nov 3, 1969, *and that death occurred at* 7:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: James R. Arthurs 900 (Degree or title) MD
23b. ADDRESS: 502 N. 2nd, Sandpoint, Idaho
23c. DATE SIGNED: 11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Westmond Cemetery
24d. LOCATION (City, town, or county): Bonner County — (State): Idaho

DATE REC'D BY LOCAL REG.: 11/25/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5102
Local Reg. No. #103
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091 — NOV 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho ID
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 711 N. Florence

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Wilhelmina	Marie	Peine	November 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	December 24, 1909	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Otto Koelsch	Kansas	Julis Loch	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----------	524 32 8160	Anton Peine	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignancy, breast — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) type unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

1918

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1958, *to* Nov 5, 1969, *that I last saw the deceased alive on* Nov 5, 1969, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 38?	Sandpoint Ida	11-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 8, 1969	Pack River Cemetery	Bonner County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11/14/69	[signature]	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 0 6 1995

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5103
Local Reg. No. 2108
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 26 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN: Sandpoint
LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN: Sandpoint
d. STREET ADDRESS (If rural, give location): 401 Lake Street

3. NAME OF DECEASED (Type or Print): a. (First) Margueritte b. (Middle) Kathleen c. (Last) Twist

4. DATE OF DEATH (Month) (Day) (Year): November 9, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 26, 1910

9. AGE (In years last birthday): 59 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore L. Berger BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Ida Mae Ryan BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: No information

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cirrhosis — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1969 *to* Nov, 1969, *that I last saw the deceased alive on* Nov 9, 1969 *and that death occurred at* 8:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 382 (Degree or title) MD
23b. ADDRESS: Sandpoint Ida
23c. DATE SIGNED: 11-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Memorial Park
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 11/24/69
REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Dale G. Coffelt LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 7 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5104
Local Reg. No. # 119
Reg. Dist. No.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 14 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 040

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Jennie
b. (Middle): Florence
c. (Last): Martin

4. DATE OF DEATH: November 13, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct 25, 1878

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter W. Bales
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Mollie V. Inskeep
BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518 24 9418 D

17. INFORMANT'S OWN SIGNATURE: Lola M. Cunningham
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Probable Coronary artery

DUE TO (c): disease and — 1 week

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Pneumonia

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan 8, 19 59, *to* Nov 13, 19 69, *that I last saw the deceased alive on* Oct 9, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] H71 (Degree or title): M.D.
23b. ADDRESS: Sandpoint, Idaho 83864
23c. DATE SIGNED: 11/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3
24b. DATE: Nov 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Arco Cemetery
24d. LOCATION (City, town, or county) (State): Arco Idaho

DATE REC'D BY LOCAL REG.: 12/3/69
REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5105
Local Reg. No. #109
Reg. Dist. No.

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give place): Sandpoint
c. LENGTH OF STAY IN THIS PLACE: Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): N.P. R.Y. Streamliner (Depot)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington
b. COUNTY: King
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Seattle
d. STREET ADDRESS (If rural, give location): 11660 Renton Avenue

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) Bernard c. (Last) Kelly

4. DATE OF DEATH: (Month) (Day) (Year) November 17, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: January 18, 1911

9. AGE (In years last birthday): 58
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: King County

11. BIRTHPLACE (State or foreign country): Butte Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James M. Kelly
BIRTHPLACE: Ireland

14. MOTHER'S MAIDEN NAME: Ellen Leary
BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: Unobtainable

17. INFORMANT'S OWN SIGNATURE: Ed Kelly by L. G. Moon Jr. ADDRESS: Sandpoint

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (c): — INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Cancer — months

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Danny D. Nelson Coroner Bon. County

23b. ADDRESS: Sandpoint Idaho

23c. DATE SIGNED: 11/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 11-18, 1969

24c. NAME OF CEMETERY OR CREMATORY: Butte Cemetery

24d. LOCATION (City, town, or county) (State): Butte, Montana

DATE REC'D BY LOCAL REG.: 11/25/69

REGISTRAR'S SIGNATURE: Hale Nicholson

25. EMBALMER: L.G. Moon Jr
LICENSE NO.: E.405
FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 9 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5106
Local Reg. No. #113
Reg. Dist. No.

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (In this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 718 Pine Street

3. NAME OF DECEASED (Type or Print)
a. (First): Jalmer
b. (Middle):
c. (Last): Cook

4. DATE OF DEATH (Month) (Day) (Year): November 20, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: April 17, 1886
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Finland
12. CITIZEN OF WHAT COUNTRY?: Finland

13. FATHER'S NAME: No information — BIRTHPLACE: Finland
14. MOTHER'S MAIDEN NAME: No information — BIRTHPLACE: Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 518 60 4874 T
17. INFORMANT'S OWN SIGNATURE: ✓ Elsie Kajander — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 404X Atherosclerotic Cardio-

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Vascular Renal Disease 10 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1961, *to* Nov, 1969, *that I last saw the deceased alive on* Nov 19, 1969, *and that death occurred at* 8P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Munson MD 382
23b. ADDRESS: Sandpoint Ida
23c. DATE SIGNED: 11-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: Nov 25, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moon Crematory
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 12/3/69
REGISTRAR'S SIGNATURE: Hale Pedersen
25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5107
Local Reg. No. # 112
Reg. Dist. No.

RECEIVED DEC 2 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 041
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 1 hour

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 041
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 517 Church Street

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

3. NAME OF DECEASED (Type or Print): a. (First) Earl b. (Middle) William c. (Last) Lee

4. DATE OF DEATH (Month) (Day) (Year): November 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 5, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woods worker 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Lee
BIRTHPLACE: No record

14. MOTHER'S MAIDEN NAME: Lottie Mae Headlee
BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 05 2382

17. INFORMANT'S OWN SIGNATURE: Nellie R. Lee
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 11 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 16, 1966, *to* Nov. 21, 1969, *that I last saw the deceased alive on* Nov. 20, 1969, *and that death occurred at* 3:35a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Helen Peterson M.D. 415

23b. ADDRESS: Box 159, Sandpoint, Idaho

23c. DATE SIGNED: 11/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: Nov 25, 1969

24c. NAME OF CEMETERY OR CREMATORY: Moon Crematory

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 12/1/69

REGISTRAR'S SIGNATURE: Hallie Robinson

25. EMBALMER: L. G. Moon, Jr.

LICENSE NO.: E-405

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: APR 17 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
DEC 12 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5108
Local Reg. No. #117
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 090
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Priest River
c. LENGTH OF STAY (In this place): 10 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonner 090
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Priest River
d. STREET ADDRESS (If rural, give location): Lincoln St.

3. NAME OF DECEASED (Type or Print): a. (First) Lee b. (Middle) William c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year): Nov 23 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar 16 1894
9. AGE (In years last birthday): 75 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operating Engineer 11
10b. KIND OF BUSINESS OR INDUSTRY: Heavy Const.
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Williams — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Mary Wrappe — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 531 18 9909
17. INFORMANT'S OWN SIGNATURE: Mrs. Lee Williams — ADDRESS: Box 631 Priest River Id.

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Seen after *to* death *, 19____, that I last saw the deceased alive on* Dec 8 *, 19*65*, and that death occurred at* about 12:00 a *m., from the causes and on the date stated above.*

23a. SIGNATURE: Robert Warn Winston 608 (Degree or title) MD
23b. ADDRESS: Newport, Wash
23c. DATE SIGNED: 11/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 11/26/69
24c. NAME OF CEMETERY OR CREMATORY: Newport Cemetery
24d. LOCATION (City, town, or county) (State): Newport Wash.

DATE REC'D BY LOCAL REG.: 12/10/69
REGISTRAR'S SIGNATURE: Hale Pedersen
25. EMBALMER: David Sherman
LICENSE NO.: QL749

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Sherman Funeral Home, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969
MAR 18 1970
JUL 28 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5109
Local Reg. No. # 115
Reg. Dist. No.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 09C
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sagle
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Franciska b. (Middle) c. (Last) Fox

4. DATE OF DEATH (Month) (Day) (Year): November 25, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 19, 1891

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Staudenmaier
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME:
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 46 2781

17. INFORMANT'S OWN SIGNATURE: Mary E. Bostic
ADDRESS: Sagle, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic cardio-vascular disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 18, 1967, *to* Nov. 25, 1969, *that I last saw the deceased alive on* Nov. 25, 1969 *and that death occurred at* 8:55p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Glenn Peterson M.D.
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 11/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 29, 1969
24c. NAME OF CEMETERY OR CREMATORY: Seneacquoteen Cemetery
24d. LOCATION (City, town, or county) (State): Bonner County Idaho

DATE REC'D BY LOCAL REG.: 12/3/69
REGISTRAR'S SIGNATURE: Hale Nickerson

25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 23 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 18 1976

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5110
Local Reg. No. #122
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Bonner 091 — DEC 22 1969 — Bureau of Vital Statistics — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint — LENGTH OF STAY (in this place): 8 1/2 yrs — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 091

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Bonner 091 — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint — d. STREET ADDRESS (If rural, give location): 419 South Olive Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Carl	--	Formoe	November 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Feb. 12, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 11	Construction	Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Formoe	Norway	Helena Trytrud	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W W I 3	473 01 0778 B	Mrs Carl Formoe	419 Olive ave

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: some

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cardio vascular renal disease — 5 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-22, 1969, *to* 11-29, 1969, *that I last saw the deceased alive on* 9-26, 1969, *and that death occurred at* 7:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O J Mauerman 327 MD	Sandpoint Idaho	12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 3, 1969	Pinecrest Memorial Park	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/19/69	Hale Anderson	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 24 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5111
Local Reg. No. #116
Reg. Dist. No.

BIRTH NO.

RECEIVED DEC 11 1969 Vital Statistics Bureau of Health

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonner 090
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Samuels
LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 802

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Samuels
d. STREET ADDRESS (If rural, give location): Route 1, Box 20

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Harold	Jay	Westfall	Nov. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	Dec 12, 1893	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Own farm	Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Westfall	New York	Estella Showers	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----------	518 18 4653	Paul Westfall	Samuels, Idaho

MEDICAL CERTIFICATION

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Barry D. Nelson 583 4	Coroner	Sandpoint Idaho	12/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 5, 1969	Pinecrest Memorial Park	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/9/69	Hale Nielsen	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 21 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5112
Local Reg. No. 400
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Eddie Hotel, West Broadway 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Unknown 13
b. COUNTY: Unknown 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Unknown
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROBERT	LOPEZ	QUINONES	Sept. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Mexican	Unknown	July 26, 1935	34		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 06	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor& Upholsterer	General	Unknown	Unk.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unk.	436 62 1563	Police Records	Ida. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 929X Hemorrhage (Subdural and subleptomeningeal)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13101	(COUNTY)	(STATE)
accident	In apt. 15	Idaho Falls	Bonneville	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Sept 04 69 Early AM m.		Fist fight with neighbor

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Verna Bydalch 583	Coroner 4	3824 E 17th Idaho Falls Idaho	12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 29, 69	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 6-1969	Anna Bridges	Buck Sullivan	E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5113
Local Reg. No. 478
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED DEC 16 1969 Vital Statistics Bureau of Health

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 2 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Victor
d. STREET ADDRESS (If rural, give location): none

3. NAME OF DECEASED (Type or Print): a. (First) EMMA b. (Middle) ALICE c. (Last) PORTER

4. DATE OF DEATH: (Month) (Day) (Year) October 10, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowd

8. DATE OF BIRTH: Oct 13, 1888

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Nephi, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alvis Teague
BIRTHPLACE: North Carolina

14. MOTHER'S MAIDEN NAME: Alice Fletcher
BIRTHPLACE: North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-54-1041

17. INFORMANT'S OWN SIGNATURE: X Helen P. De Wolf
ADDRESS: Jackson, Wyo.

8199

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asthma (acute respiratory

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) insufficiency) precipitated

DUE TO (c) by automobile accident.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Victor Teton Idaho

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) Oct 10 69 7:30 p.m.

21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Verna Bydalch 583 (Degree or title) Coroner.

23b. ADDRESS: 3824 E 17th ~~Idaho~~ Idaho Falls Idaho

23c. DATE SIGNED: 12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct 14, 1969

24c. NAME OF CEMETERY OR CREMATORY: Victor Cemetery

24d. LOCATION (City, town, or county) (State): Victor, Teton Co., Idaho

DATE REC'D BY LOCAL REG.: Dec. 12-'69

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Robert Q. Bean
Leo Williams

LICENSE NO. E456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-630 21

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5114
Local Reg. No. 370
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (In this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1256 Tower

3. NAME OF DECEASED (Type or Print): a. (First) Merle; b. (Middle) Jean; c. (Last) Meppen

4. DATE OF DEATH (Month) (Day) (Year): October 26 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 20, 1935

9. AGE (In years last birthday): 33
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Receptionist & Stenographer 19
10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): Butte, Montana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Guy H. Simpson
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Juanita Gilliard
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 34 1518

17. INFORMANT'S OWN SIGNATURE: Arlyn W. Meppen
ADDRESS: Idaho Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) [redacted]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestion and extended thrombosis to other cerebral veins and dural sinuses,
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Edema and congestion, moderate, brain. Early hemorrhagic necrosis, cerebral cortex in frontoparietal areas, focal

INTERVAL BETWEEN ONSET AND DEATH: 5 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1961 *to* 10-26, 19 69, *that I last saw the deceased alive on* 10-26, 19 69, *and that death occurred at* 4:00 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/30/69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 18-69

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 1 7 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5115
Local Reg. No. 395
Reg. Dist. No. 610

BIRTH NO.

DEC 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Idaho Falls c. LENGTH OF STAY (If in hospital):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042	d. STREET ADDRESS (If rural, give location): 2015 Bremmer Dr.

3. NAME OF DECEASED (Type or Print)	a. (First) CLARA	b. (Middle) ELIZABETH	c. (Last) AUSTIN	4. DATE OF DEATH (Month) (Day) (Year)	Oct. 29, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Aug. 26, 1886	9. AGE (In years last birthday): 83	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Domestic	11. BIRTHPLACE (State or foreign country): Gove City, Kansas	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Charles Smith	BIRTHPLACE: New Jersey	14. MOTHER'S MAIDEN NAME: Malinda Bell	BIRTHPLACE: Iowa		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518 44 3562	17. INFORMANT'S OWN SIGNATURE: Rev. Donald F. Austin	ADDRESS		

2509

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Diabetes mellitus.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Cerebral thrombosis.

INTERVAL BETWEEN ONSET AND DEATH: 6 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 10-29, 19 69, *that I last saw the deceased alive on* 10/29, 19 69, *and that death occurred at* 11:55a *m., from the causes and on the date stated above.*

23a. SIGNATURE: R. K. Frantzmann 294 (Degree or title)	23b. ADDRESS: Idaho Falls, Idaho 83401	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Nov. 1, 69	24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho
DATE REC'D BY LOCAL REG.: Nov. 26 '69	REGISTRAR'S SIGNATURE: Anne A. Bridges	25. EMBALMER: [signature]	LICENSE NO.: E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5116
Local Reg. No. 369
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Rest Home 345

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Good Samaritan Rest Home

3. NAME OF DECEASED (Type or Print): a. (First) FRANKLIN b. (Middle) * c. (Last) HUNT

4. DATE OF DEATH (Month) (Day) (Year): Oct. 29, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 3, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grower of

10b. KIND OF BUSINESS OR INDUSTRY: Green house

11. BIRTHPLACE (State or foreign country): Grand Meadow, Minn.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Martin Lewis Hunt
BIRTHPLACE: Unk

14. MOTHER'S MAIDEN NAME: Edah Blanche Wilsie
BIRTHPLACE: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 538 03 3390

17. INFORMANT'S OWN SIGNATURE: Ray F. Hunt
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral vascular stroke

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-4-69 *, 19____, to* 10-29-69 *, 19____, that I last saw the deceased alive on* 10-29-69 *, 19____, and that death occurred at* 3 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton T. Rees M.D. 432

23b. ADDRESS: Idaho Falls Ida

23c. DATE SIGNED: 11-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 1, 69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 20-1969

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Buck Sullivan

LICENSE NO.: E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969
AUG 1 9 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5117
Local Reg. No. 371
Reg. Dist. No. 610

BIRTH NO. 1880

RECEIVED NOV 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bonneville 01	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Clark 170
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dubois
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location) Rural Dubois

3. NAME OF DECEASED (Type or Print)	a. (First) ISABEL	b. (Middle) *	c. (Last) STELZER	4. DATE OF DEATH (Month) (Day) (Year) Oct. 29, 1969
5. SEX Female	6. COLOR OR RACE Whtte	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH November 22 - 1880	9. AGE (In years last birthday) 88 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Plain City, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas A. Robson	BIRTHPLACE England	14. MOTHER'S MAIDEN NAME Lucretia C. Loveles,	BIRTHPLACE Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519 28 3979A	17. INFORMANT'S OWN SIGNATURE Annie Mitchell	ADDRESS Dubois, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 weeks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* June, 1969, *to* 29 Oct, 1969, *that I last saw the deceased alive on* 29 Oct, 1969, *and that death occurred at* 5:30 pm *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 503 W. Stoddard Cruz	23b. ADDRESS Idaho Falls, Idaho	23c. DATE SIGNED 15 Nov 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE Nov. 3, 1969	24c. NAME OF CEMETERY OR CREMATORY Dubois Cemetery	24d. LOCATION (City, town, or county) (State) Dubois, Ida.
DATE REC'D BY LOCAL REG. Nov. 20-69	REGISTRAR'S SIGNATURE Anna Bridger	25. EMBALMER Buck Sullivan	LICENSE NO. E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 9 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5118
Local Reg. No. 368
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (If in place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Nursing Home 042	d. STREET ADDRESS (If rural, give location) 272 Hill St.

3. NAME OF DECEASED (Type or Print)	a. (First) JACOB	b. (Middle) SEVERIN	c. (Last) ADOLPHSON	4. DATE OF DEATH (Month) (Day) (Year) Nov. 1, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 25, 1884	9. AGE (In years last birthday) 85 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter&Farmer 21	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Rumskulla, Sweden	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adolph Johannson	BIRTHPLACE Sweden	14. MOTHER'S MAIDEN NAME Unk	BIRTHPLACE Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519 10 1486A	17. INFORMANT'S OWN SIGNATURE Mrs. Arline Mai	ADDRESS IF,I	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7130

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bronchial Pneumonia	2 da
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Osteo-Arthritis	15 yrs
DUE TO (c)	Chronic Pyelocystitis	1½ yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. *, 19*50*, to* Nov 1. *, 19*69*, that I last saw the deceased alive on* Oct. 31 *, 19*69 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE T. T. Erickson 161 (Degree or title) M.D.	23b. ADDRESS Idaho Falls, Idaho	23c. DATE SIGNED 11-10-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 4, 69	24c. NAME OF CEMETERY OR CREMATORY New Sweden Cemetery	24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho
DATE REC'D BY LOCAL REG. NW 15-69	REGISTRAR'S SIGNATURE Ann A Bridger	25. EMBALMER [signature]	LICENSE NO. E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 2 2 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5119
Local Reg. No. 357
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 241 East 2nd North Street

3. NAME OF DECEASED (Type or Print): a. (First) KARL b. (Middle) HENRY c. (Last) JONES

4. DATE OF DEATH (Month) (Day) (Year): Nov. 1, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 28, 1897

9. AGE (In years last birthday): 72 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (07)

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): North Ogden, Utah.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Jones — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Rhoda Berrett — BIRTHPLACE: Ogden, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-03-9571

17. INFORMANT'S OWN SIGNATURE: Ethel Jones — ADDRESS: Rigby, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1857

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized metastatic Carcinoma — 2 years
DUE TO (c) Carcinoma Prostate — 4 years +

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary Heart Disease — 8 years

19a. DATE OF OPERATION: 1968 August.

19b. MAJOR FINDINGS OF OPERATION: Laminectomy - metastatic Carcinoma

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 26, 1965, *to* Nov. 1, 1969, *that I last saw the deceased alive on* Oct. 31, 1969, *and that death occurred at* 4:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Tall (522) — (Degree or title): M.D.

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: 4 Nov. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 4, 1969

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho.

DATE REC'D BY LOCAL REG.: Nov. 7-69

REGISTRAR'S SIGNATURE: Anna Rudger

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 12 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5120
Local Reg. No. 377
Reg. Dist. No. 6H

BIRTH NO.

RECEIVED NOV 25 1969 Bureau of Vital Statistics

Weeks

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. HOSPITAL 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): 400 I St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LUCILLE	TARBET	STARR	Nov 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	married	18 March 1894	75	7 / 14	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Lewiston, Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Harris Fife	Providence, Utah	Mary Elizabeth Stocks	Draper, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Joe Tarbet	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction 8

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) due to arteriosclerotic heart disease.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 30, 1969, to Nov 2, 1969, *that I last saw the deceased alive on* Nov 2, 1969, *and that death occurred at* 6:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
556 Byron T Weeks MD	Idaho Falls, Idaho	11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 6, 1969	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 21 1969	Verna Bridges	Leo A Williams	E--319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 18 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5121
Local Reg. No. 372
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 112 East 16th Street (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 112 East 16th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
OrReva		Graham	November 3 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Jan. 25, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Beauty Operator 21	Beauty Shop	Shelley, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elias H. Gardner	Utah	Elsie Dockstader	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 20 9749	Claude L Graham	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction Suspect — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7 May, 1955 *to* 3 Nov., 1969, *that I last saw the deceased alive on* 2 July, 1968, *and that death occurred at* 12:20 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	795 Bland Idaho Falls	11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/6/69	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 19 '69	Emma Bridges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5122
Local Reg. No. 367
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 20 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. CITY LIMITS (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Sacred Heart Hospital (043)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 178 East 13th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY	VIOLA	LOUTHIAN	Nov. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Fem.	White	Married	Feb 19, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Domestic	Prescott, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eugene Crow,	Illinois	Jennie Hughes,	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 07 6321A	William E. Louthian	Spokane

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-9-1961, *to* 11-3-1969, *that I last saw the deceased alive on* 11-2, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John McMillan MD	550 4th Street	11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 5, 69	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 15-69	Anna Rudjen		E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 0 1969

DEC 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 0 7 1997
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5123
Local Reg. No. 378
Reg. Dist. No. 610

BIRTH NO. 69-9030

RECEIVED NOV 25 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SACRED HEART HOSPITAL 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: BONNEVILLE (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) TRACY b. (Middle) LEE c. (Last) RIGOULOT

4. DATE OF DEATH: (Month) (Day) (Year): Nov 3, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): infant

8. DATE OF BIRTH: 19 Sept 1969

9. AGE (In years last birthday): IF UNDER 1 YR. Months / Days: 1 / 16; IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant (02)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Victor Rigoulot — BIRTHPLACE: Idaho Falls, Ida.

14. MOTHER'S MAIDEN NAME: Kathy Hymas — BIRTHPLACE: Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Infant

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: William Victor Rigoulot — ADDRESS:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) craniosynostosis (7560) — INTERVAL BETWEEN ONSET AND DEATH: at birth

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: she died following surgery for the craniosynostosis on 11-3-69

19a. DATE OF OPERATION: 11-3-69

19b. MAJOR FINDINGS OF OPERATION: craniosynostosis of sagital suture

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-2- , 1969, *to* 11-3- , 1969, *that I last saw the deceased alive on* 11-3- , 1969, *and that death occurred at* 3:02p m., *from the causes and on the date stated above.*

23a. SIGNATURE: George J. Barnard M.D. (027) (Degree or title)

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 11-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6 Nov 1969

24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: 11-21-'69

REGISTRAR'S SIGNATURE: Emma Rudger

25. EMBALMER: Leo A. Williams

LICENSE NO.: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5124
Local Reg. No. 395
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 9 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Theodore
b. (Middle): Alfonso
c. (Last): Barsalou

4. DATE OF DEATH (Month) (Day) (Year): Nov. 4, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 10, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Challis, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Millan Stowell Hicks — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Frankie M. Tremper — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-09-7359
17. INFORMANT'S OWN SIGNATURE: Margaret Barsalou — ADDRESS: Salmon, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

150X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Esophagus — INTERVAL BETWEEN ONSET AND DEATH: Circ 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Carcinoma of Rt. Kidney
Carcinoma of Prostate

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct. 10, 1969, *to* Nov. 4, 1969, *that I last saw the deceased alive on* Nov. 5, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 359
23b. ADDRESS: 544-4th Idaho Falls Ida
23c. DATE SIGNED: 11/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Dec. 5-1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Bill Sullivan
LICENSE NO.: E387

Federal Security Agency
United States Public Health Service
Form DH-63020
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 1 1 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 19 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5125
Local Reg. No. 573
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Montana 27 b. COUNTY: Silver Bow 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 1 hour	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Butte
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042	d. STREET ADDRESS (If rural, give location): 20 Casey Street

3. NAME OF DECEASED (Type or Print)	a. (First): Nellie	b. (Middle):	c. (Last): Strasser	4. DATE OF DEATH (Month) (Day) (Year): November 4 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Jan. 15, 1890	9. AGE (In years last birthday): 79 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Butte, Montana	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Joseph Simonich	BIRTHPLACE: Austria	14. MOTHER'S MAIDEN NAME: Josephine Mehelich	BIRTHPLACE: Austria	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: Not Available	17. INFORMANT'S OWN SIGNATURE: Mrs J. W. Reece	ADDRESS: Butte, Mont.	

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): chest injury

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): auto accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 19__, *to* ——, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 5:20 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE: A. Wm R[illegible] (Degree or title) 633	23b. ADDRESS: Idaho Falls, Idaho	23c. DATE SIGNED: 11-7-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 11/5/69	24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Gardens	24d. LOCATION (City, town, or county): Butte (State): Montana
DATE REC'D BY LOCAL REG.: Nov. 19-'69	REGISTRAR'S SIGNATURE: Anna Bridges	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-11565

RECEIVED NOV 20 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5126
Local Reg. No. 366
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LDS Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Steven
b. (Middle): Lewis
c. (Last): Wellard

4. DATE OF DEATH (Month) (Day) (Year): Nov. 5, 1969

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: Nov. 2, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 3; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rexburg, Idaho
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Jerry D. Wellard
BIRTHPLACE: Rexburg, Idaho
14. MOTHER'S MAIDEN NAME: Linda Lou Oakden
BIRTHPLACE: Idaho Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 2 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Jerry D Wellard
ADDRESS: Rexburg, RFD 2

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7769

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Atelectasis, fetal — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Prematurity — 3 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 2 November 1969, *to* 5 November 1969, *that I last saw the deceased alive on* 5 November 1969, *and that death occurred at* 10:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Russel Flamm 164
23b. ADDRESS: Idaho Falls Idaho
23c. DATE SIGNED: 13 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 11/6/69
24c. NAME OF CEMETERY OR CREMATORY: Wilford Cemetery
24d. LOCATION (City, town, or county) (State): Wilford, Fremont, Idaho

DATE REC'D BY LOCAL REG.: Nov. 14-1969
REGISTRAR'S SIGNATURE: Anna Bredger
25. EMBALMER: Russel Flamm
LICENSE NO.: E-254

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5127
Local Reg. No. 380
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonnville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 310 Capital Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 310 Capital Ave.,

3. NAME OF DECEASED (Type or Print)
a. (First) Leland
b. (Middle) Dale
c. (Last) Cox

4. DATE OF DEATH (Month) Nov (Day) 6 (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH April 17 1917
9. AGE (In years last birthday) 52
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Jameston, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Levi A. Cox
BIRTHPLACE Franklin, Idaho
14. MOTHER'S MAIDEN NAME Elnora Arave
BIRTHPLACE Hooper, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-30-1320
17. INFORMANT'S OWN SIGNATURE Lewis Cox
ADDRESS R#1 Shelley Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severe arteriolosclerotic Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Idaho Falls (COUNTY) Bonne. (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Vernal Bydalek 553 Coroner (Degree or title)
23b. ADDRESS 3824 E. 17th
23c. DATE SIGNED 11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov 10 1969
24c. NAME OF CEMETERY OR CREMATORY Taylor Cemetery
24d. LOCATION (City, town, or county) Idaho Falls, Bingham (State) Idaho

DATE REC'D BY LOCAL REG. NW. 21-1969
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER [signature] Nalder's Funeral Home Shelley, Idaho
LICENSE NO. E275

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 7 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5128
Local Reg. No. 377
Reg. Dist. No. C/6

BIRTH NO.

RECEIVED NOV 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Rest Home 348

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 120 N. Morningside

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Harriet	Erminnie Black	Garner	November 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	April 21, 1871	98		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George David Black		Mary Hunt	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		[signature]	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) + arteriosclerotic U.S.
DUE TO (c) + failure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* 10-13-69, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	1050 Memorial Dr. Idaho Falls, Idaho	11-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 11-1969	Wilford Cemetery	Rural St. Anthony, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21-1969	[signature]	David C Hansen	E-510

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5129
Local Reg. No. 482
Reg. Dist. No. 670

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
DEC 16 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samatarian Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony,
d. STREET ADDRESS (If rural, give location): 36 No. Bridge

3. NAME OF DECEASED (Type or Print): a. (First) OTOMAKU b. (Middle) "TOGO" c. (Last) TANIGUCHI

4. DATE OF DEATH: (Month) Nov., (Day) 6. (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Japanease

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: March 15, 1884

9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Kushimoto, Japan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: UNKNOWN — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: UNKNOWN — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-07-0038

17. INFORMANT'S OWN SIGNATURE: x Kiyoshi Sakata — ADDRESS: Rexburg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, suspected — INTERVAL BETWEEN ONSET AND DEATH: 5 Days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — many years

4867

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Aug, 1964, *to* 5 Nov., 1969, *that I last saw the deceased alive on* 5 Nov., 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Tim O. Johnson — (Degree or title): M.D

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: 13 Nov. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12 Nov 69

24c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

24d. LOCATION (City, town, or county) (State): St. Anthony, Idaho

DATE REC'D BY LOCAL REG.: Dec. 1 1969

REGISTRAR'S SIGNATURE: Irma Bridges

25. EMBALMER: Bruce Erickson

LICENSE NO.

Federal Security Agency
United States Public Health Service

Form DH-6302

FIRM NAME:

DEC 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5130
Local Reg. No. 374
Reg. Dist. No. 616

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 207 Jefferson St.

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) WILLARD c. (Last) H AWKINS

4. DATE OF DEATH: (Month) November (Day) 8, (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: October 26, 1910

9. AGE (In years last birthday): 59
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician 08

10b. KIND OF BUSINESS OR INDUSTRY: Idaho Nuclear Corp.

11. BIRTHPLACE (State or foreign country): Aspen, Colo.

12. CITIZEN OF WHAT COUNTRY?: U.S. A.

13. FATHER'S NAME: Rance Hawkins
BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Stella Lewis
BIRTHPLACE: Aspen, Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 528-05-8240

17. INFORMANT'S OWN SIGNATURE: Eleanor Hawkins
ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 402X Organic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 3 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiomegally Aortic aneurysm — 3 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-7, 19 69, *to* November 8, 19 69, *that I last saw the deceased alive on* November 8, 19 69, *and that death occurred at* 5:35 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 515 (Degree or title): M.D.
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: Nov 11, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 3
24b. DATE: November 11, 69
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county): Shelley (State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 19-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E-466
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 26 1969
DEC 8 1969
FEB 20 1979
JUL 22 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 9 1969 Bureau of Vital Statistics

State File No. 5131
Local Reg. No. 387
Reg. Dist. No. 616

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jefferson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Terreton
d. STREET ADDRESS (If rural, give location): Box 63

3. NAME OF DECEASED (Type or Print): a. (First) Albert; b. (Middle) Lester; c. (Last) Burkey

4. DATE OF DEATH (Month) (Day) (Year): November 9 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: August 28, 1886

9. AGE (In years last birthday): 83
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Farming & Building

11. BIRTHPLACE (State or foreign country): Milford, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Burkey
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Paulina Neumann
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 03 4355

17. INFORMANT'S OWN SIGNATURE: Elsie A. Kindred
ADDRESS: Terreton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pulmonary Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-26- , 19 64 , *to* 11-9- , 19 69 , *that I last saw the deceased alive on* 11/8 , 1969 , *and that death occurred at* 8:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 294 (Degree or title): MD

23b. ADDRESS: Idaho Falls, Idaho 83401

23c. DATE SIGNED: 11-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/12/69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 1-1969

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Ralph M. Wood [signature]

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 30 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5132
Local Reg. No. 391
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: DOA: L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Colonial Motel

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DORMAN	FREDRICK	GILES	Nov. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 28, 1920	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Roofing Contractor	Self	Baudette, Minn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Darwin J. Giles	Minnesota	Anna Wyman	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW II	543 01 4040	Mrs. Alene Giles	IF, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arterio sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4123

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
1746 I. M. Mitchell	M.D.	L.D.S. Hosp. Idaho Falls, Ida	11/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 12, 1969	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	EMBALMER	LICENSE NO.
NOV 22 '69	Anna Rudgier		E387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 5 1969

DEC 1 6 1969

DEC 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 2 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 1 2 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5133
Local Reg. No. 375
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Montana 27
b. COUNTY Silver Bow 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Butte
d. STREET ADDRESS (If rural, give location) 20 Casey

3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) B c. (Last) Strasser

4. DATE OF DEATH (Month) (Day) (Year) November 9 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH July 30, 1893
9. AGE (In years last birthday) 76 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baggage Agent 10
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Butte, Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Barney Strasser BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Mary Reitly BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Not Available
17. INFORMANT'S OWN SIGNATURE June Reece ADDRESS Butte, Montana

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerbral contussions — INTERVAL BETWEEN ONSET AND DEATH 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 00000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11 - 4 69 2 30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? auto accident

22. *I hereby certify that I attended the deceased from* 11-4, 1969, *to* death, 19____, *that I last saw the deceased alive on* 11-8, 1969, *and that death occurred at* 2 am *m., from the causes and on the date stated above.*

23a. SIGNATURE 633 A. [signature] for MO (Degree or title)
23b. ADDRESS Idaho Falls
23c. DATE SIGNED 11-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 11/9/69
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens
24d. LOCATION (City, town, or county) Butte (State) Montana

DATE REC'D BY LOCAL REG. Nov. 19 1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Ralph M. Wood [signature]
LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended December 10, 1969

Certificate of Death
STATE OF IDAHO

State File No. 5134
Local Reg. No. 376
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (07)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Don	M.	Beardall	November 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 18, 1938	31		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Surveyer 08	Highway Department	Rexburg, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel H. Beardall	Burton, Idaho	Garnet Muir	Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-34-9195	Garnet Beardall	Rexburg, Idaho

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Respiratory Failure	days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pulmonary Injury	"
DUE TO (c)	Auto accident	"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	subdural hygroma	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov 7, 1969	Subdural hygroma	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
/	06	00002

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Nov 3 69 1 AM m.		Auto accident

22. *I hereby certify that I attended the deceased from* 3 Nov, 19 69, *to* Death, 19 ____, *that I last saw the deceased alive on* 10 Nov, 19 69, *and that death occurred at* 10 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas Higgs, M.D. 230	2065 E. 17th	14 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov 14, 1969	Burton	Rexburg Rt 1 Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 19, 1969	Anna Bridges	Kenneth Flamm	E347

FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED

DEC 9 1969

Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death) for Don M. Beardall (Name on Original Certificate) who died (Was Born or Died) on November 10, 1969 (Date of Event) in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#7	Divorced	Married

Subscribed and sworn to before me this 5th day of December, 19 69

Notary Public, residing at Rexburg, Idaho

My commission expires June 25, 1971

(Seal)

Signed Garnet Beardall

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

75 S 5 W. Rexburg, Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Madison }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 5th day of December 1969

Notary Public, residing at Rexburg, Idaho

My commission expires June 25, 1969

(Seal)

Signed Russell Hamm

(Signature of Any Credible Person)

131 N 3 E. Rexburg, Idaho

(Street Address, City, State)

FORM DH 60-155

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 376
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Bonneville

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Madison

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DON	M.	BEARDALL	November 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	June 18, 1938	31		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Surveyer

10b. KIND OF BUSINESS OR INDUSTRY: Highway Department

11. BIRTHPLACE (State or foreign country): Rexburg, Idaho

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel H. Deardall — BIRTHPLACE: Burton, Idaho

14. MOTHER'S MAIDEN NAME: Garnet Muir — BIRTHPLACE: Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-34-9195

17. INFORMANT'S OWN SIGNATURE: Garnet Beardall — ADDRESS: Rexburg, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pulmonary Injury — INTERVAL BETWEEN ONSET AND DEATH: "

DUE TO (c) auto accident — INTERVAL BETWEEN ONSET AND DEATH: "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Subdural Hygroma

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7 Nov 69	Subdural Hygroma	YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Nov 3 69 1:00 p.m.		auto accident

22. *I hereby certify that I attended the deceased from* 3 Nov, 1969, *to* Death, 19__, *that I last saw the deceased alive on* 10 Nov, 1969, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	2065 E - 17th	14 Nov 69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 14, 1969	Burton	Rexburg, Rt. 1 Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 19-69	Irma Bridges	[signature]	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 - inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 4 1969

DEC 10 1969

DEC 12 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5135
Local Reg. No. 391
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
DEC 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY (101) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (In this place) 88 months
d. FULL NAME OF HOSPITAL OR INSTITUTION IDS Extended Care Unit (042)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY (101) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 242 East 16th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Zelma	Arminta	Gosselin	November 11 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	June 15, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Own Home	Pullman, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alma Gustin	Utah	Susannah Cloward	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	528 07 6130D	Velta G. Simpson	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	A S H D & Cerebral Arteriosclerosis	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. H. Baker 018 M.D.	Idaho Falls	11-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11/14/69	Sunset Memorial Gardens	Twin Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4-1969	Anna Budge	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 27 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5136
Local Reg. No. 396
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital Rest Home 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: ~~Ida~~ Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Idaho Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): MARGIE
b. (Middle): *
c. (Last): SCHLUTER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 27, 1884
9. AGE (In years last birthday): 84
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Tabor, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Myers
BIRTHPLACE: Unk.
14. MOTHER'S MAIDEN NAME: Sarah McCoy
BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 58 3813
17. INFORMANT'S OWN SIGNATURE: Herman Schluter
ADDRESS: Ririe, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH: Cmo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-4- *, 19*58*, to* 11-11 *, 19*69*, that I last saw the deceased alive on* 11/5 *, 19*69*, and that death occurred at* 5:30 *pm., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 294 (Degree or title)
23b. ADDRESS: IDAHO FALLS, IDAHO 83401
23c. DATE SIGNED: 11/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 14, 69
24c. NAME OF CEMETERY OR CREMATORY: Ririe-Shelton Cem.
24d. LOCATION (City, town, or county) (State): Ririe, Idaho

DATE REC'D BY LOCAL REG.: Dec. 5-1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 15 1972
JAN 5 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5137
Local Reg. No. 382
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 810 Sonja St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 810 Sonja St.

3. NAME OF DECEASED (Type or Print): a. (First) RICHARD; b. (Middle) ELLSWORTH; c. (Last) ELD

4. DATE OF DEATH: (Month) Nov. (Day) 14, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Mar. 4, 1965

9. AGE (In years last birthday): 4
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Marvin Eld
BIRTHPLACE: Aitkin, Minn.

14. MOTHER'S MAIDEN NAME: Sharon Nystrom
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Marvin E. Eld
ADDRESS: 810 Sonja, ID

8147

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pulmonary Hemorrhage due to trauma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Crushing injury, chest

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT XX / SUICIDE / HOMICIDE 1 (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 04 Street in front of

21c. (CITY, TOWN, OR TOWNSHIP) 13101 (COUNTY) (STATE): home Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY: (Month) 11-14-69 (Day) (Year) (Hour) 12:30p.m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Child struck by an automobile

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Charles R. Bosworth (053) (Degree or title)

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 17, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Ida.

DATE REC'D BY LOCAL REG.: Nov. 22-69

REGISTRAR'S SIGNATURE: Emma Bridges

25. EMBALMER: Buck Sullivan

LICENSE NO.: E387

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 25 1969
NOV 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

DEC 9 1969
DEC 16 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

DEC 8 1969

Bureau of Vital Statistics

State File No. 5138
Local Reg. No. 396
Reg. Dist. No. 610

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1875 JeppsonAve.

3. NAME OF DECEASED (Type or Print): a. (First) TWYLIA b. (Middle) KIMBLE c. (Last) DAVIS

4. DATE OF DEATH: (Month) Nov. (Day) 16, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 29, 1931

9. AGE (In years last birthday): 38
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Moundsville, W. Virg.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Luther W. Kimble
BIRTHPLACE: W. Virginia

14. MOTHER'S MAIDEN NAME: Hazel I Brannan
BIRTHPLACE: W. Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 298 26 4581

17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: Ida. Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 191X Astrocytoma, brain — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-16, 1967, *to* 11-16, 1969, *that I last saw the deceased alive on* 11-16-69, 19____, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 546 (Degree or title)

23b. ADDRESS: Idaho Falls, Ida

23c. DATE SIGNED: 11-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Nov. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Garrard County Cemetery

24d. LOCATION (City, town, or county) (State): Lancaster, Kentucky

DATE REC'D BY LOCAL REG.: NOV 25 1969

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature]

LICENSE NO.: E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

DEC 9 1969
AUG 16 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED NOV 28 1969 Bureau of Vital Statistics

State File No. 5139
Local Reg. No. 383
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
c. USUAL RESIDENCE (In this place): YES
d. FULL NAME OF HOSPITAL OR INSTITUTION: RESIDENCE

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): 140 East 17th St.

3. NAME OF DECEASED (Type or Print): a. (First) FERN b. (Middle) WALTON c. (Last) LIVINGSTON

4. DATE OF DEATH (Month) (Day) (Year): Nov 16, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept 13, 1906

9. AGE (In years last birthday): 63
IF UNDER 1 YR. Months: 2 Days: 3
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 06

10b. KIND OF BUSINESS OR INDUSTRY: Potato Processing

11. BIRTHPLACE (State or foreign country): Auburn, Wyoming

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Joseph Henry Walton
BIRTHPLACE: Bountiful, Utah

14. MOTHER'S MAIDEN NAME: Mary Annie Wheelock
BIRTHPLACE: Bountiful Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-24-0107

17. INFORMANT'S OWN SIGNATURE: Earl D Livingston
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary thrombosis
INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriolosclerotic heart disease.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1954, 19__, *to* 1969, 19__, *that I last saw the deceased alive on* 5-28-, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: John S Horton MD (Degree or title)
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 11-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 18, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov 25 69
REGISTRAR'S SIGNATURE: Anna Rudge
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5140
Local Reg. No. 387
Reg. Dist. No. 610

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 DEC 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Idaho Falls Bureau of Vital Statistics
c. LENGTH OF STAY: 1 wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
d. STREET ADDRESS (If rural, give location): main Street

3. NAME OF DECEASED (Type or Print)
a. (First): Ernest
b. (Middle): Leon
c. (Last): Sant

4. DATE OF DEATH (Month) (Day) (Year): Nov 16, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 28, 1911
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk 08
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Hyde Park, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ernest C. Sant — BIRTHPLACE: Treasureton, Idaho
14. MOTHER'S MAIDEN NAME: Jennie Christina Nelson — BIRTHPLACE: Hyde Park, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 528-16-7450
17. INFORMANT'S OWN SIGNATURE: Karen Hatch — ADDRESS: Tetonia, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 14 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 2, 1969, *to* Nov 16, 1969, *that I last saw the deceased alive on* Nov 16, 1969, *and that death occurred at* 11:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Byron T Weeks MD 556
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 11-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Nov 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Driggs Cemetery
24d. LOCATION (City, town, or county) (State): Driggs, Idaho

DATE REC'D BY LOCAL REG.: Nov 28-69
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Robert Bean Robert Bean — LICENSE NO. E-456

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Robert Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 14 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5141
Local Reg. No. 392
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY (101) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 919 Blaine Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY (101) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 919 Blaine Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Carlos	Elmer	McCombs	November 17 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 28, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
A. C. Andrew McCombs	USA	Ellen Gray	Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Beth Clapp	Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) myocardial infarction

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic Heart disease
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 1969, to Nov 17, 1969, that I last saw the deceased alive on Nov. 14, 1969, and that death occurred at ? m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron T. Weeks MD (556)	Idaho Falls, Idaho	Nov. 25, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/20/69	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4-1969	Emma Rudger	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 0 1969

MAR 3 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5142
Local Reg. No. 481
Reg. Dist. No. 611

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1969
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 1/2 Mi So. E. of Ammon 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Ammon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JEROME	HANS	KELLER	Nov. 18, 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 23, 1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Car Wash Operator 22	Self	Glenco, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Heber T. Keller	Mink Creek, Utah		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 09 1283	Jerry B. Keller	835 E. 13th Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Heart Disease 4299	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	pt had had open Heart Surgy	
DUE TO (c)	1 year previous	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
11 - 18 - 69 3:00 P.M.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Verna Bydalch 583 (Degree or title) Coroner	3804 E. 17th Idaho Falls Idaho	12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	22 Nov. 69	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 6-1969	Anna Budge		E387

FIRM NAME: Buck Sullivan Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

MAY 2 3 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 28 1969 Bureau of Vital Statistics

State File No. 5143
Local Reg. No. 344
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (In this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 120 5th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 120 5th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Harmon	McKenzie	Groesbeck	November 19 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 16, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner & Operator 22	Furnace Company	Eureka, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Willaim Jesse Groesbeck	Utah	Hilia McKenzie	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1 3	519 09 1428	Billy T. Groesbeck	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Coronary infarction	30 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary heart disease	8 yrs 8 mos
DUE TO (c)	Right + left bundle branch block	6 yrs 3 mos
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from March, 1961, to Nov 19, 1969, that I last saw the deceased alive on Nov 19, 1969, and that death occurred at 3:50 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hugh B. Hawley M.D	Idaho Falls, Idaho	11/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/22/69	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE*	25. EMBALMER	LICENSE NO.
Nov 25-69	Anna Budge	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

Delivered to Registrar November 25,1969 DEC 1 1969

DEC 2 7 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5144
Local Reg. No. 378
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
c. LENGTH OF STAY (In this place) 1969
d. FULL NAME OF HOSPITAL OR INSTITUTION 298 8th St. Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO
b. COUNTY BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
d. STREET ADDRESS (If rural, give location) 370 Falls Dr

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELLEN	BEE [redacted]	SMITH	Nov 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	3 March 1903	66	8	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ogden, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Andrew Nelson
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Salina Horrocks
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Robert W Edwards
ADDRESS 370 Falls, Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Insufficiency — 1-2 years
DUE TO (c) Hypertensive-Cardio-Vascular Disease — few years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MARCH, 1960, to November, 1969, that I last saw the deceased alive on Nov 19, 1969, and that death occurred at 11-19-69 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 503
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 25 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov 22, 1969	Fielding Memorial Park	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 1 1969	Anna Rudges	Leo A Williams	E319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5145
Local Reg. No. 397
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville 701
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 265 Taupphaus Dr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location): Idaho Falls, Idaho

3. NAME OF DECEASED (Type or Print) a. (First): DEIDRICK	b. (Middle): W.	c. (Last): JAHN	4. DATE OF DEATH (Month) (Day) (Year): Nov. 20, 69	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Sept. 15, 1892	9. AGE (In years last birthday): 77 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer, retired 04	10b. KIND OF BUSINESS OR INDUSTRY: Self	11. BIRTHPLACE (State or foreign country): Struble, Iowa	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Diedrick John	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Rika Unk	BIRTHPLACE: Germany	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519 42 7639	17. INFORMANT'S OWN SIGNATURE: Robert John	ADDRESS: Rt. #4 Box 167 IF IDA.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-17, 19 63, *to* 11-20-, 19 69, *that I last saw the deceased alive on* 11/19, 19 69, *and that death occurred at* 3:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. T. Franz 294	(Degree or title): M. D.	23b. ADDRESS: IDAHO FALLS, IDAHO 83401	23c. DATE SIGNED: 11/27/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Nov. 22, 69	24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho
DATE REC'D BY LOCAL REG.: Dec. 5-1969	REGISTRAR'S SIGNATURE: Anna Bridges	25. EMBALMER: Bock Sullivan	LICENSE NO.: E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Bock-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5146
Local Reg. No. 398
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 9 1969 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital Extended Care.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewisville
d. STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print): a. (First) BERTHA b. (Middle) IDELL c. (Last) SAUER

4. DATE OF DEATH (Month) (Day) (Year): November 21, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 23, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Grant, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lyman Amasa Taylor
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Maria Done
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-16-4215

17. INFORMANT'S OWN SIGNATURE: Shirley S. Sexton
ADDRESS: Lewisville, Idaho.

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3-4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 11yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS, BONNEVILLE, IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6- , 19 55 , *to* 11-21 , 19 69 , *that I last saw the deceased alive on* 11/16 , 1969 , *and that death occurred at* 2:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): M.D.
23b. ADDRESS: Idaho Falls, Idaho.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Central
24d. LOCATION (City, town, or county) (State): Grant Jefferson Idaho

DATE REC'D BY LOCAL REG.: Dec. 5-1969
REGISTRAR'S SIGNATURE: Emma Rudges

25. EMBALMER: Bruce A. Eckersell
LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5147
Local Reg. No. 398
Reg. Dist. No. 610

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 DEC 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY IN THIS PLACE 1½ weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LDS Nursing Home 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	KATHERINE	CAMERON	McKAY

4. DATE OF DEATH (Month) (Day) (Year): Nov. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Widowed	Mar. 6, 1889	80	8	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Charleston, Scotland	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Cameron	Scotland	Mary Shepherd	Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-07-5203D	Hugh C McKay	St. Anthony Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary occlusion — hours

DUE TO (c) Arteriosclerotic heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractured Femur.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 22 Nov, 1969 *to* 22 Nov, 1969, *that I last saw the deceased alive on* 22 Nov, 1969 *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Joseph M Nalen MD 211	Idaho Falls Idaho	25 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	11-26-69	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 29 69	Anna Bridges	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5148
Local Reg. No. 399
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LDS NURSING HOME 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) NANCY ELLEN b. (Middle) RAWLINS c. (Last) STOCKS

4. DATE OF DEATH (Month) (Day) (Year) Nov., 22, 1969

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH August 1, 1874
9. AGE (In years last birthday) 95 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Retired 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lewiston, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harvey M. Rawlins — BIRTHPLACE Green County, Ill.
14. MOTHER'S MAIDEN NAME Margaret Frost — BIRTHPLACE Knoxville, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-07-4288
17. INFORMANT'S OWN SIGNATURE x Alt Prophet — ADDRESS Box 242 Rigby.

2509

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Diabetes mellitus — INTERVAL BETWEEN ONSET AND DEATH 4 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) IDAHO FALLS, BONNEVILLE, IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-29-, 1969, *to* 11-22-, 1969, *that I last saw the deceased alive on* 11/21, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE R. K. Krantz 294 (Degree or title) M. D.
23b. ADDRESS IDAHO FALLS, IDAHO 83401
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE 25 Nov 69
24c. NAME OF CEMETERY OR CREMATORY Pioneer Cemetery
24d. LOCATION (City, town, or county) (State) Rigby, Jefferson County, Idaho

DATE REC'D BY LOCAL REG. Dec. 5-1969
REGISTRAR'S SIGNATURE Anna Bridger
25. EMBALMER M. D. Hansen — M. D. Hansen
LICENSE NO. E-354

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5149
Local Reg. No. 393
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY in this place: Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2890 Ammon-Lincoln Road

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 2890 Ammon-Lincoln Road

3. NAME OF DECEASED (Type or Print): a. (First) Laura; b. (Middle); c. (Last) Woodhouse

4. DATE OF DEATH: (Month) November (Day) 23 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: February 15, 1893

9. AGE (In years last birthday): 76
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Wallingsford, Kentucky

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Cook
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Barbara Krimmer
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Sylvia E. Silver
ADDRESS: Salt Lake, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Coronary occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arterioschlerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-10-1949, 19____, *to* 11-23-69, 19____, *that I last saw the deceased alive on* 11-23-69, 19____, *and that death occurred at* 3 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton T. Rees M.D.

23b. ADDRESS: 148 N. Corner Ave

23c. DATE SIGNED: 11-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/26/69

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county): Idaho Falls (State): Idaho

DATE REC'D BY LOCAL REG.: Dec. 4-69

REGISTRAR'S SIGNATURE: Anna Budge

25. EMBALMER: Ralph M. Wood Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5150
Local Reg. No. 394
Reg. Dist. No. 61

BIRTH NO.

RECEIVED DEC 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 455 So. Skyline Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 455 So. Skyline Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Paul	Thomas	Philippe	November 26 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	November 23, 1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Office Manager "	Indrustrial Contr.	Mason City, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marion Greene Philippe	Indiana	Margaret Loyola Neville	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 11	478 14 7061	John E Philippe	Los Angeles

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 5351 Duodenitis with aspiration — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Heavy Smoker, heavy Coke drinker

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
	455 S. Skyline Drive	Idaho Falls	Bonne.	Idaho.

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
11 -	26 -	69	6:0Am.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Verna Bydalch	Coroner	3884 E. 17th Idaho Falls.	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	11/29/69	Rose Hill Cemetery	Idaho Falls	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4-1969	Anna Bredjer	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 9 1969

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JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5151
Local Reg. No. 403
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 658 North Water Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 658 North Water Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Frederick(Fred) b. (Middle) Lewis c. (Last) Somers

4. DATE OF DEATH: (Month) November (Day) 26 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 26, 1901

9. AGE (In years last birthday): 68
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Music

11. BIRTHPLACE (State or foreign country): St. Anthony, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frederick B. Somers
BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Elizabeth Bainbridge
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: not available

17. INFORMANT'S OWN SIGNATURE: Mrs. Frederick Somers
ADDRESS: Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 4 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10 , 1964 , *to* 11/26 , 19 69 , *that I last saw the deceased alive on* 1 , 19 , *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)

23b. ADDRESS: Idaho Falls, Ida

23c. DATE SIGNED: 12/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/29/69

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 11-1969

REGISTRAR'S SIGNATURE: Anne Rudges

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 1 9 1970
MAR 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5152
Local Reg. No. 404
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 16 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location) 190 South Corner

3. NAME OF DECEASED (Type or Print) a. (First) MAYBELLE b. (Middle) IRENE c. (Last) LOGAN

4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan 13, 1888

9. AGE (In years last birthday) 81
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Domestic

11. BIRTHPLACE (State or foreign country) Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Kerr
BIRTHPLACE Unk.

14. MOTHER'S MAIDEN NAME Fannie Rumary
BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 09 1042 D

17. INFORMANT'S OWN SIGNATURE Mae L. Wengert
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Generalized arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH: Several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Terminal Pneumonia -
3-4 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19 68, to Nov. 27, 19 69, that I last saw the deceased alive on Nov. 27, 19 69, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE 208 Harvey A. Hatch (Degree or title) M.D.

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED Dec. 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Entomb

24b. DATE Nov 29, 69

24c. NAME OF CEMETERY OR CREMATORY Mausoleum, RoseHill Cem.

24d. LOCATION (City, town, or county) Idaho Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 11-1969

REGISTRAR'S SIGNATURE Anna Burgess

25. EMBALMER Buck Sullivan

LICENSE NO. E387

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 19 1969
MAR 27 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 16 1969 Bureau of Vital Statistics

State File No. 5153
Local Reg. No. 405
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY BONNEVILLE 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY BONNEVILLE 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042	d. STREET ADDRESS (If rural, give location) Lewisville

3. NAME OF DECEASED (Type or Print)	a. (First) ELSIE IRENE	b. (Middle) AUSTIN	c. (Last) BEAUMONT	4. DATE OF DEATH (Month) (Day) (Year) Nov 28, 1969
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 21 Jan. 1915	9. AGE (In years last birthday) 54 — IF UNDER 1 YR. Months 10 Days 7 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Trenton, Utah	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Moffite Austin	BIRTHPLACE Trenton, Utah	14. MOTHER'S MAIDEN NAME Sarah Elizabeth Simpson	BIRTHPLACE Downey, Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Clarence Beaumont	ADDRESS	

9220

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) gunshot wound thru rt chest, diaphragm, liver, with

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ex-sanguination

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2 hours

19a. DATE OF OPERATION

19b. MAJOR FINDINGS ~~OF OPERATION~~ AUTOPSY as above

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE 1 (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 31	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13000	
21d. TIME OF INJURY (Month) 11 (Day) 28 (Year) 69 (Hour) 12:30 p.m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR? Removing gun from truck	

22. *I hereby certify that I attended the deceased from* For 30 min in Emery 19 ___ *, that I last saw the deceased alive on* about 2 pm Nov 28 1969 *, and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE J Harr 081 (Degree or title) MD	23b. ADDRESS 750 Oxford Idaho Falls Idaho	23c. DATE SIGNED 12-3-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2 Dec. 1969	24c. NAME OF CEMETERY OR CREMATORY Fielding Memorial Park,	24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho
DATE REC'D BY LOCAL REG. Dec. 9-1969	REGISTRAR'S SIGNATURE Anna Bredger	25. EMBALMER Leo A. Williams	LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5154
Local Reg. No. 406
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 16 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital. 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Montana 27
b. COUNTY: Beaverhead 035
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dillon
d. STREET ADDRESS (If rural, give location): Rt. 1 Box 72-A

3. NAME OF DECEASED (Type or Print): a. (First) Baby Boy b. (Middle) Webster c. (Last) Grant

4. DATE OF DEATH: (Month) 11 (Day) 29 (Year) 69

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Nov 27, 1969

9. AGE (In years last birthday): IF UNDER 1 YR. Months 3 Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Dillon Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cary Grant BIRTHPLACE: Dillon Mont.

14. MOTHER'S MAIDEN NAME: Denise Webster BIRTHPLACE: Dillon Montana.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Denise Webster Grant ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Anopenia — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Respiratory failure (CNS) — 1 hour
DUE TO (c): Etiology undetermined

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

7769

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 29 November 1969, *to* 29 November 19 69, *that I last saw the deceased alive on* 29 November, 19 69, *and that death occurred at* 11:40 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: 3 Dec 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 3

24b. DATE: 12-2-69

24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

24d. LOCATION (City, town, or county) (State): Dillon Beaverhead Montana.

DATE REC'D BY LOCAL REG.: Dec. 11-1969

REGISTRAR'S SIGNATURE: Lenna Rudges

25. EMBALMER: Ralph M Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5155
Local Reg. No. 407
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 16 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY (101) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 96 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LDS Extended Care Unit 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho (13)
b. COUNTY (101) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1129 Blaine Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thelma		Hope	November 30 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	December 1, 1896	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Own Home	Teton City, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John William Gardner	England	Janette Muir	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 42 8077A	✓ Dorothy Dentle	Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4377

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
(18) R. A. Baker DMD	Idaho Falls	12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial (3)	12/3/69	Teton Cemetery	Teton Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 11-1969	Anna Bridges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH–63021

FEB 13 1970
DEC 24 1969
NOV 13 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5156
Local Reg. No. 407
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 225 Tabor

3. NAME OF DECEASED (Type or Print): a. (First) Nash; b. (Middle); c. (Last) Welch

4. DATE OF DEATH: November 30 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 13, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer 06

10b. KIND OF BUSINESS OR INDUSTRY: Maintenance

11. BIRTHPLACE (State or foreign country): Morgan, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Nash Welch
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Sarah Coulam Heiner
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 520 01 0384

17. INFORMANT'S OWN SIGNATURE: Kathlyn S. Welch ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 2 yrs
DUE TO (c): arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Nov 29 1969

19b. MAJOR FINDINGS OF OPERATION: Left iliofemoral venous thrombosis

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 28, 1969, to Nov 30, 1969, that I last saw the deceased alive on Nov 30, 1969, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE: Warren A. Sutton (Degree or title) MD

23b. ADDRESS: 555 So Blvd Idaho Falls, Idaho

23c. DATE SIGNED: 12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 12/3/69

24c. NAME OF CEMETERY OR CREMATORY: Cowley Cemetery

24d. LOCATION (City, town, or county): Cowley (State): Wyoming

DATE REC'D BY LOCAL REG.: Dec. 11-1969

REGISTRAR'S SIGNATURE: Emma Bridges

25. EMBALMER: Ralph M. Wood Ralph M Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FEB 16 1970
APR 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended Nov 13, 1969

Certificate of Death
STATE OF IDAHO

State File No. 5157
Local Reg. No. 50-69
Reg. Dist. No. 100

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Boundary "
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Naples
c. LENGTH OF STAY (In this place): 25 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home on Star Route

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Boundary "
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Naples
d. STREET ADDRESS (If rural, give location): Star Route

3. NAME OF DECEASED (Type or Print): a. (First) Louis b. (Middle) John c. (Last) Boucher

4. DATE OF DEATH (Month) (Day) (Year): November 1, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept 23, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter "

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Grand Forks, North Dakota

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Charles Boucher
BIRTHPLACE: Maine

14. MOTHER'S MAIDEN NAME: Angelina Scott
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 516-09-9444

17. INFORMANT'S OWN SIGNATURE: Ethel Boucher
ADDRESS: Naples, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Occlusion — Interval between onset and death: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — Years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigation Only *, 19__, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: C. M. Callahan, Coroner (Degree or title) 583

23b. ADDRESS: Bonners Ferry, Idaho

23c. DATE SIGNED: 11-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-6-69

24c. NAME OF CEMETERY OR CREMATORY: Moravia Cemetery

24d. LOCATION (City, town, or county): Bonners Ferry (State): Idaho

DATE REC'D BY LOCAL REG.: Nov 1, 1969

REGISTRAR'S SIGNATURE: Twyla Stone

25. EMBALMER: Charles O. Malone

LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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11-6-69

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for Louis John Bouchier (Name on Original Certificate) who died (Was Born or Died) on Nov. 1, 1969 (Date of Event)

in Boundary County (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 3c	Bouchier	Boucher
Item 13	Bouchier	Boucher

Subscribed and sworn to before me this 8 day of November, 1969

Marion Mesenbrink

Notary Public, residing at Bonners Ferry Ida

My commission expires 3-1-73

(Seal)

Signed F M Williams
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Bonners Ferry, Idaho.
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Boundary }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 8th day of November, 1969

Marion Mesenbrink

Notary Public, residing at Bonners Ferry

My commission expires 3-1-73

(Seal)

Signed Bethesda Memorial Chapel By: Margaret Sullivan, Owner
(Signature of Any Credible Person)

Box 808 - Bonners Ferry Idaho.
(Street Address, City, State)

FORM DH 60-155

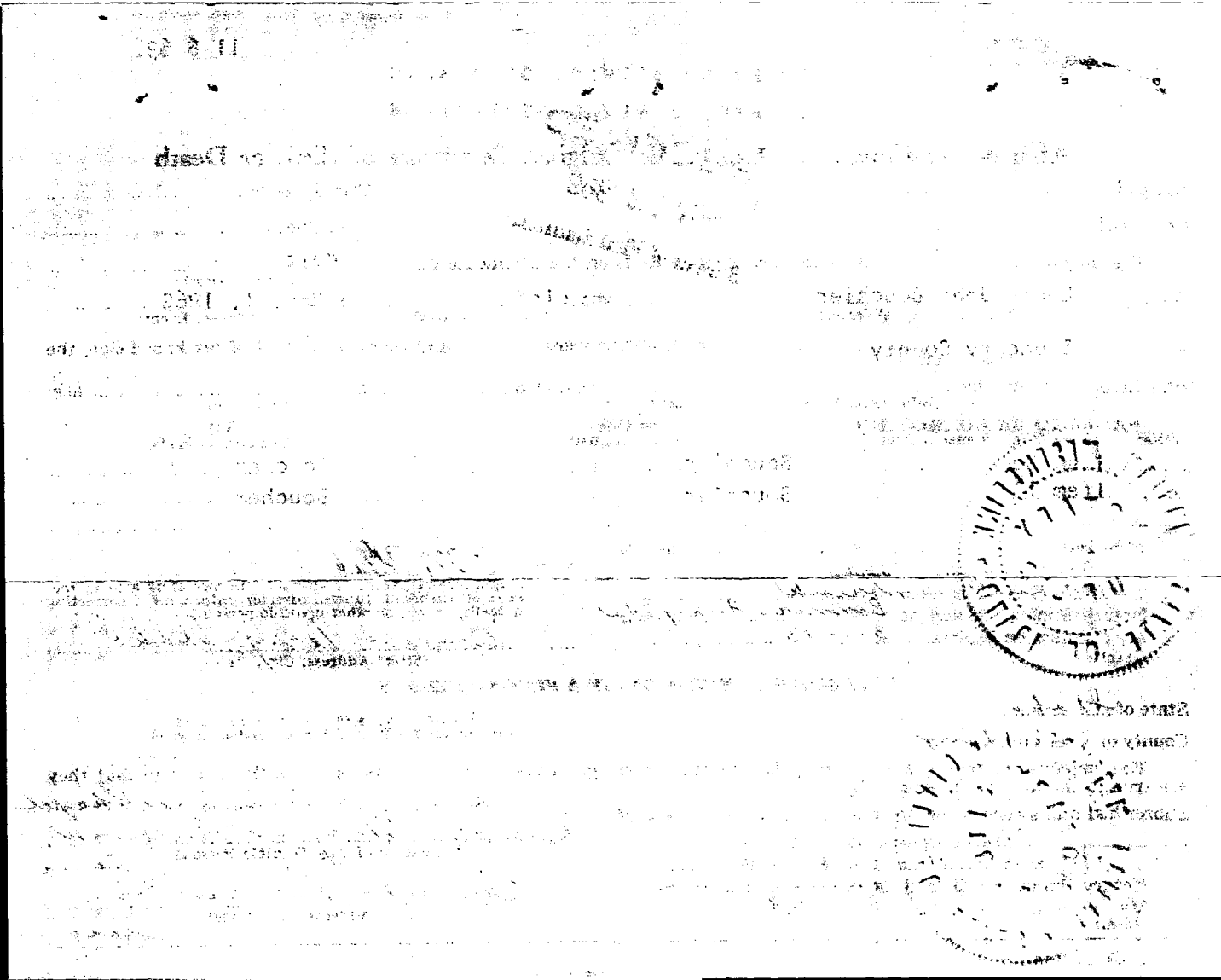

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 6 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 50-69
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Naples
LENGTH OF STAY (in this place) 25 years

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Naples
d. STREET ADDRESS (If rural, give location) Star Route

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home on Star Route

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LOUIS	JOHN	BOUCHIER	November 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married-	Sept. 23, 1899	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Construction	Grand Forks, North Dakota	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Bouchier	Maine	Angelina Scott	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	—	516-09-9444	Ethel Bouchier	Naples, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclotic Heart Disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Callahan Coroner	Bonners Ferry, Idaho	11/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/6/69	Moravia Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 1, 1969	Pamela Stone	Charles Wilson	E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5158
Local Reg. No. 54-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED DEC 12 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN: Naples
c. LENGTH OF STAY (If this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway #95

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): P O Box 233

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	HERMAN	PAUST	KROGSETH	11	16	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	7 - 6 - 1919	50				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner-operator 22	Automobile Serv.	Naples, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Knute Krogseth	Norway	Anna Christina Flor	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 4	519-05-4824	Rudy A. Krogseth	E 107 12- 19th Spokane, Wn.

8199

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple rib fractures on r. hemithorax on the posterior axillary line.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Fractured fragments being primarily at the 5 through 12 inclusive.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractured Skull

INTERVAL BETWEEN ONSET AND DEATH: Instant

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 06	Naples 13110 Boundary Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
11-16-1969 m.		Automobile Accident

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 7:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C M. Callahan 583 Coroner	Box 302 Bonners Ferry, Idaho 83805	12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-21-69	Grandview Cemetery	Boundary County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 9, 1969	Twyla Stone	Emile Dion	E536

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

DEC 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 6 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

JAN 15 1970

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5159
Local Reg. No. 52-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Naples
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway #95-Six miles S. of Naples

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 415 S. 18th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Denny	L.	Timonen	November 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Dec. 6, 1945	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman 08	CDA Fire Dept.	Rexburg, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Heimo Timonen	Unknown	Doris Bingham	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Viet Nam 7	519-50-7783	Heimo H. Timonen	Coeur d'Alene, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8169

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Massive Skull Fracture	Instant
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Massive Trauma	Instant
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	6 mi. South of Naples, Ida	Naples	Boundary	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
11/27/69 7:50P. m.		Car left Highway at high speed

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C M Callahan 583	Coroner 4	Bonners Ferry, Idaho	12/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11-28-1969	English Funeral Chapel	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4, 1969	Evelyn Stone	Emile Dion	E-536

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hillcrest Memorial Chapel

DEC 12 1969

JAN 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 9 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5160
Local Reg. No. 53-69
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Montana
b. COUNTY Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
d. STREET ADDRESS (If rural, give location) P. O. Box #114

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MINNIE	MARTHA	KIRSCHBAUM	November 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	Sept. 15, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 00	None	Chippewa, Michigan	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Kirschbaum	Michigan	Mary Fry	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	516-54-9664	J. E. Kirschbaum	Post Falls, Idaho

4360

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA — INTERVAL BETWEEN ONSET AND DEATH 15 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11/15, 1969, *to* 11/30, 1969, *that I last saw the deceased alive on* 11/30, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward 153 M.D.	Bonners Ferry	12/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12/3/69	Milner Cemetery	Troy Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/6/69	Virgila Stone	Emile Dion	E-536

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF ~~THIS ITEM. In case a person has resided~~ in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5161
Local Reg. No. 553
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 CANYON — NOV 25 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY in this place
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LASHERS NURSING HOME 358

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO 13 — b. COUNTY CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 472 NAMPA-CALDWELL BLVD.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLAUDE	J.	STEIN	OCTOBER 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
M	WHITE	NEVER MARRIED	SEPT. 26, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RET. LABORER 06		NO RECORD	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
NO RECORD		NO RECORD	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	383-07-9232 A	Family Records. By: Jay S. Brouse	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) ASHD & enlarged heart — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebrovascular insuff — 6 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma prostate — 2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov 58 to Oct 69, that I last saw the deceased alive on Oct 13, 1969, and that death occurred at 11:15 A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Nampa Idaho	10 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	OCT. 31, 1969	WILDER CEMETERY	WILDER IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 24, 1969	Mrs Martina Walmsley	Richard W. Meserve	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5162
Local Reg. No. 534
Reg. Dist. No. 360

Certificate of Death

RECEIVED
NOV 12 1969
Bureau of Vital

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 140
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma Rural
c. LENGTH OF STAY (in this place): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hwy # 95 5 Miles N. Parma 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
d. STREET ADDRESS (If rural, give location): 504 Iowa

3. NAME OF DECEASED (Type or Print)
a. (First): Billy
b. (Middle): Ivory
c. (Last): Day

4. DATE OF DEATH (Month) (Day) (Year): Nov. 1, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 29, 1940
9. AGE (In years last birthday): 29 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Office 08
10b. KIND OF BUSINESS OR INDUSTRY: City of Fruitland
11. BIRTHPLACE (State or foreign country): Nyssa, Oregon
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Claud Day — BIRTHPLACE: Colorado
14. MOTHER'S MAIDEN NAME: Lois Hoffman — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 541-46-6732
17. INFORMANT'S OWN SIGNATURE: Barbara L. Day — ADDRESS: Fruitland,

18. CAUSE OF DEATH 8129
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Broken Neck

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto Accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 95 north of Parma 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Canyon 13140 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 1 1969 5:20 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Head on collision with a truck

22. *I hereby certify that I attended the deceased from* Inspection only, *19*____, *to* _____, *19*____, *that I last saw the deceased alive on* _____, *19*____, *and that death occurred at* 5:20 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesche 583 4 — (Degree or title): M. D. Coroner
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: II-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Nov. 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Nyssa Cemetery
24d. LOCATION (City, town, or county) (State): Nyssa Oregon

DATE REC'D BY LOCAL REG.: Nov. 10, 1969
REGISTRAR'S SIGNATURE: Irene N. Kanta R.U.
25. EMBALMER: Milford D. Oregon
LICENSE NO.: E318

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Lienkaemper Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

NOV 18 1969

FEB 4 1970

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5163
Local Reg. No. 537
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (40)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Parma
c. LENGTH OF STAY (in this place): Moments
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hwy 95, Near Payette & Canyon County Line (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette (380)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
d. STREET ADDRESS (If rural, give location): 233 Third St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Joe	Dallas	HORN	November 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	August 25, 1942	27	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Deputy Sherriff CS	Law Enforcement	Amity, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harlon P. Horn	Arkansas	Taylor Mae Rudolph	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- -	541-44-9041	Mrs Kathleen J. Horn	Fruitland, Idaho

8129

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken Neck — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto Accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Crushed Chest--Chin Laceration
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	highway 95 North of Parma	(06) 13140	Canyon	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Nov 1 1969 5:20 P.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Head on collision with a truck

22. *I hereby certify that I attended the deceased from* Inspection Only, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 5:20 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wesche 583	M. D. Coroner	Nampa Idaho	11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Removal-Burial	11-6-1969	Rosedale	Payette	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Irene N Kanta RN.	Keith W. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. FEB 4 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 5164
Local Reg. No. 549
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY (141) Canyon — NOV 2 0 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY IN (this place) 3 months

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (142)
a. STATE Idaho b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1611-1st St. So.,

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blakely Nursing Home (177)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDGAR	N.	BENNETT	Nov. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Feb. 10, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired (07)	Mining	Baker, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elmer Bennett	Pennsylvania	Ora M. Williams	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	535-20-1114A	+ Edith L. Olsen	Wash. Spokane.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive failure due to

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic degenerative heart disease and
DUE TO (c) Chronic pulmonary disease & Pneumonia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from November 8, 1960, to November 3, 1969, that I last saw the deceased alive on November 2, 1969, and that death occurred at 10:40A. m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jo Kellogg (275)	M.D.	Caldwell Idaho	14 November 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 6, 1969	Kohlerlawn Cemetery	Nampa Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 19, 1969	Mrs. Martina Walmsley	Marvin R. Gledhill	E 515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5165
Local Reg. No. 541
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: CANYON 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050	d. STREET ADDRESS (If rural, give location): 260 DELEWARE

3. NAME OF DECEASED (Type or Print) a. (First): DOROTHY	b. (Middle): LENORE	c. (Last): JOHNSON	4. DATE OF DEATH (Month) (Day) (Year): NOVEMBER 3, 1969	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED	8. DATE OF BIRTH: DEC. 24, 1913	9. AGE (In years last birthday): 55 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE 01	10b. KIND OF BUSINESS OR INDUSTRY: HOME	11. BIRTHPLACE (State or foreign country): HAYS, KANSAS	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: ORA J. BROWN	BIRTHPLACE: IOWA	14. MOTHER'S MAIDEN NAME: MINNIE M. VAN ROYEN	BIRTHPLACE: HOLLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-28-7313	17. INFORMANT'S OWN SIGNATURE: Lewis C Johnson	ADDRESS: NAMPA, IDA.	

18. CAUSE OF DEATH 5770
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Intestinal Obstruction	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Post Op. Adhesions	
DUE TO (c)	Previous Abdominal Surgery	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Mill Pancreatitis.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 5:00 PM 2 Nov, 1969, *to* 5:00 AM 3 Nov, 1969, *that I last saw the deceased alive on* 3 Nov, 1969, *and that death occurred at* 5:00A. *m., from the causes and on the date stated above.*

23a. SIGNATURE 3rd J R Mangum Mm (Degree or title)	23b. ADDRESS Nampa, Idaho	23c. DATE SIGNED 7 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	24b. DATE: NOV. 6, 1969	24c. NAME OF CEMETERY OR CREMATORY: KOHLERLAWN CEMETERY	24d. LOCATION (City, town, or county): NAMPA	(State): IDAHO
DATE REC'D BY LOCAL REG.: Nov. 13, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: [signature]	LICENSE NO.: E-496	

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 4 1969
NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 12 1969 Bureau of Vital Statistics

State File No. 5166
Local Reg. No. 533
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 515 Locust

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nora	(nmn)	Brown	Nov. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 24, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Maker 01	At Home	Eastland County, Texas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John C. Gage	Texas	Mollie E. Johnson	Mississippi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518 54 5434	x Elva C. Kenna	Nampa, Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Compression Fracture L 1 — 3 wks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-1 1964 *to* 11-4 1969 *that I last saw the deceased alive on* 11-3 1969 *and that death occurred at* 12:50A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. C. Horton M.D.	Nampa, Idaho	11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-6-69	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Irene N. Kanta RN	M. B. Shepherd	473

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH–63021

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5167
Local Reg. No. 536
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 615 17th Ave. South

3. NAME OF DECEASED (Type or Print) a. (First) Clyde b. (Middle) E. c. (Last) Hicks

4. DATE OF DEATH (Month) (Day) (Year) Nov. 4, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 7, 1882
9. AGE (In years last birthday) 86 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Inspector 08
10b. KIND OF BUSINESS OR INDUSTRY City of Nampa
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Louis S. Hicks BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME Mary Valintine BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1905 to 1908 8
16. SOCIAL SECURITY NO. 519 12 3508A
17. INFORMANT'S OWN SIGNATURE X Vivienne L. Shonnette ADDRESS Los Altos, Cal.

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Infarction
DUE TO (c) Old Age

INTERVAL BETWEEN ONSET AND DEATH } sudden

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/24/ *, 19* 42 *to* 11/4/ *, 19* 69 *, that I last saw the deceased alive on* 11/4/ *, 19* 69 *, and that death occurred at* 7:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE 454 Jos Salter MD (Degree or title)
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 11/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-7-69
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. Nov. 10, 1969
REGISTRAR'S SIGNATURE Irene N. Kante RN
25. EMBALMER M. B. Shepherd
LICENSE NO. 473
FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969
APR 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5168
Local Reg. No. 540
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 13 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Wilder
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Rt. #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY County 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Wilder
d. STREET ADDRESS (If rural, give location) Rt. # 1

3. NAME OF DECEASED (Type or Print) a. (First) Reese b. (Middle) Edward c. (Last) Bayless

4. DATE OF DEATH (Month) (Day) (Year) Nov. 5, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Jan. 25, 1886

9. AGE (In years last birthday) 83
IF UNDER 1 YR. Months 9 Days 10
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 28

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Dodge City, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Bayless BIRTHPLACE Ill.

14. MOTHER'S MAIDEN NAME Nancy McGilgary BIRTHPLACE Dorchester, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-07-0482

17. INFORMANT'S OWN SIGNATURE W. Gene Bayless ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

404X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardio-vascular -renal disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~Inspection & History only~~ , 19____ , *that I last saw the deceased alive on* ____ , 19____ , *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Jenny C. Wesche. 583 4 (Degree or title) M. D. Coroner

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED Nov. 7, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 8, 1969

24c. NAME OF CEMETERY OR CREMATORY Peaceful Valley Cem.

24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 12, 1969

REGISTRAR'S SIGNATURE Mrs. Martin Walmsley

25. EMBALMER Rodney C. Dakan

LICENSE NO. E-508

FIRM NAME: Dakan Funeral Chapel, Cald. Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5169
Local Reg. No. 544
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 3 Wks
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
d. STREET ADDRESS (If rural, give location): Rt/ 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Leonard	G.	Cooley	Nov. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Nov. 18, 1924	44		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butcher	Armour Packing Co. 21	Stahl, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pearl Cooley	Mo.	Rubia Osborn	Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
Yes	W. W. 2 4		Mrs. Leonard Cooley Rt. 3 Meridian

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5321

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Generalized peritonitis	1 month
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Biliary cutaneous	1 month
DUE TO (c)	Pancreatic cutaneous fistula	1 month
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Separation of gastroduodenostomy	1 month

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-26-69	Duodenal ulcer with posterior penetration	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-25-69, 19__, *to* 11-5-69, 19__, *that I last saw the deceased alive on* 11-5-69, 19__, *and that death occurred at* 10:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Robert H. Blanc 048 (Degree or title) MD	721 Roosevelt	10 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-8-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 17, 1969	Mrs. Martina Walmsley	Geo. Cook	E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 20 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5170
Local Reg. No. 550
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN Caldwell
LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hosp. 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 141
c. CITY OR TOWN Caldwell
d. STREET ADDRESS (If rural, give location) 1209 Main Street

3. NAME OF DECEASED (Type or Print)
a. (First) Wesley
b. (Middle) Jefferson
c. (Last) McCollum

4. DATE OF DEATH (Month) (Day) (Year) Nov. 5, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 9-14-1903

9. AGE (In years last birthday) 66
IF UNDER 1 YEAR Months 1 Days 21
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Mason 31

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas J. McCollum
BIRTHPLACE Texas

14. MOTHER'S MAIDEN NAME Mary Catherine Sovill
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-07-0114A

17. INFORMANT'S OWN SIGNATURE Dana E McCollum
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3959

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive failure — INTERVAL BETWEEN ONSET AND DEATH 3-4 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aortic stenosis — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Myocardial fibrosis
CA of lung & metastases, chronic bronchitis & emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-20-69 *to* 11-5-69, 19__, *that I last saw the deceased alive on* 11-5-69, 19__, *and that death occurred at* 12:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Charles Beal M.D. 379
23b. ADDRESS 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED 11-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-10-1969
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Nov. 19, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Leonard L. Flahiff
LICENSE NO. E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5171
Local Reg. No. 543
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 17 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 142 CANYON	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050	d. STREET ADDRESS (If rural, give location) 504 WEST BIRD

3. NAME OF DECEASED (Type or Print) a. (First) RUTH	b. (Middle) J.	c. (Last) HAYES	4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 7, 1969	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 14, 1922	9. AGE (In years last birthday) 47 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & BOOKEEPER 19	10b. KIND OF BUSINESS OR INDUSTRY LIVESTOCK SALES	11. BIRTHPLACE (State or foreign country) EMMETT, IDAHO	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEWIS HAMBLIN	BIRTHPLACE IDAHO	14. MOTHER'S MAIDEN NAME RUTH MANLEY	BIRTHPLACE MINNESOTA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-14--2981	17. INFORMANT'S OWN SIGNATURE x John E Hayes	ADDRESS NAMPA, IDA.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1621

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Alveolar Cell Carcinoma of lung. — INTERVAL BETWEEN ONSET AND DEATH 6 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* Nov 7, 1969, *that I last saw the deceased alive on* 7 Nov, 19__, *and that death occurred at* 5:40A. *m., from the causes and on the date stated above.*

23a. SIGNATURE J B Marcusen 326 (Degree or title) MD	23b. ADDRESS Nampa Idaho	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 11/10/60	24c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY	24d. LOCATION (City, town, or county) (State) NAMPA, CANYON, IDAHO
DATE REC'D BY LOCAL REG. Nov. 14, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Don W Sinjiun	LICENSE NO. E-496

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969
DEC 2 1969
JAN 4 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

NOV 2 1 1969

Bureau of Vital Statistics

State File No. 5172
Local Reg. No. 551
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mtn. View Terrace Nursing Home (360)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 309 Blaine St. 4 P.M.

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) c. (Last) Marren

4. DATE OF DEATH (Month) (Day) (Year) Nov. 8, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 27, 1886

9. AGE (In years last birthday) 83
IF UNDER 1 YR. Months 0 Days 11
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OD

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME UNK
BIRTHPLACE

14. MOTHER'S MAIDEN NAME UNK
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) X

16. SOCIAL SECURITY NO. 513-07-1215-A

17. INFORMANT'S OWN SIGNATURE + Charles A. Marren
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1621 Cancer Lung — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 66, 19__, *to* Nov, 19 69, *that I last saw the deceased alive on* Nov 12, 19 69, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE Wolf E. Reynolds 437 (Degree or title) MD

23b. ADDRESS Caldwell

23c. DATE SIGNED 11/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 12, 1969

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Gardens

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Nov. 20, 1969

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Rodney W. Dakan

LICENSE NO. E-508

FIRM NAME: Dakan Funeral Chapel, Cald, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5173
Local Reg. No. 546
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 21 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Route 5

3. NAME OF DECEASED (Type or Print)
a. (First): Jesse
b. (Middle): E.
c. (Last): Bradford

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 22, 1899
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter #1
10b. KIND OF BUSINESS OR INDUSTRY: Home Building
11. BIRTHPLACE (State or foreign country): Latham, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Bradford — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Carrie Moreland — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 42 1636
17. INFORMANT'S OWN SIGNATURE: Zeba Bradford — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

486 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Oct 30-69
19b. MAJOR FINDINGS OF OPERATION: Peridiverticular Abscess Sigmoid
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1965, *to* Nov 9, 1969, *that I last saw the deceased alive on* Nov 9, 1969, *and that death occurred at* 11:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Neal E. Reynolds 437 (Degree or title): MD
23b. ADDRESS: Caldwell, Idaho
23c. DATE SIGNED: 11/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-12-69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens
24d. LOCATION (City, town, or county) (State): Canyon County, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Glen G. Siren — LICENSE NO. 498
FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 19 1969 Bureau of Vital Statistics

State File No. 5174
Local Reg. No. 547
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 552 State Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 552 State Street

3. NAME OF DECEASED (Type or Print) a. (First) CALVIN b. (Middle) c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year) Nov. 9, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan. 4, 1909
9. AGE (In years last birthday) 60 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman - P.F.E. Co. 10
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Draketown, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alexander Johnson BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME Catherine Swift BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.2 4
16. SOCIAL SECURITY NO. 211 05 1957
17. INFORMANT'S OWN SIGNATURE *Mrs. Calvin Johnson ADDRESS 552 State

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ventricular Standstill — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Infarcts 1965 & Sept 69

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1959, to Nov, 1969, that I last saw the deceased alive on Nov 8, 1969, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Gaydon Olson (Degree or title) 115
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 14 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/13/69
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State) Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG. Nov. 18, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER [signature]
LICENSE NO. E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5175
Local Reg. No. 583
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (142)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 11 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital (052)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. STREET ADDRESS (If rural, give location): 1850 South 18th.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
James		Alanis	November 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Spanish	Never married	3-29-68	1				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None (02)	None	Burley, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Tony Alanis	Burley, Idaho	Geneva Salazar	San Antonio, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Wilma Keyser	Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 3417 Hydrocephalus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pre-natal distress.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 15 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6-28, 1969, *to* 11-10-, 1969, *that I last saw the deceased alive on* 11-10-69, *and that death occurred at* 12:40P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D		12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal (3)	11-11-69	Pleasant View Cemetery	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 18, 1969	Mrs. Martina Walmsley	Glen L. Siren	498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 25 1969 Bureau of Vital Statistics

State File No. 5176
Local Reg. No. 554
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor Nursing Home 301	d. STREET ADDRESS (If rural, give location): Route #2

3. NAME OF DECEASED (Type or Print) a. (First): ARCHIE	b. (Middle): G	c. (Last): PIPKIN	4. DATE OF DEATH (Month) (Day) (Year): November 11, 1969		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Aug. 30, 1883	9. AGE (In years last birthday): 86	IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired R.R. Engineer & Policeman 10	10b. KIND OF BUSINESS OR INDUSTRY: Railroad	11. BIRTHPLACE (State or foreign country): Red Oaks, Texas	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: John W. Pipkin	BIRTHPLACE: Alabama	14. MOTHER'S MAIDEN NAME: Willie Amelia Billups	BIRTHPLACE: Alabama		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 712-05-1703	17. INFORMANT'S OWN SIGNATURE: x Edna T. Pipkin	ADDRESS: Nampa, Ida.		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

185 X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma of Prostate c

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Urinary Retention
~~DUE TO (c)~~ Generalized Arthritis Severe

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 Nov 1969 April, 1961, *to* 11 Nov, 1969, *that I last saw the deceased alive on* 11 Nov, 1969 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 322 J K Mangum MD	23b. ADDRESS: Nampa Idaho	23c. DATE SIGNED: 18 Nov 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3	24b. DATE: 11/14/69	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho
DATE REC'D BY LOCAL REG.: Nov. 24, 1969	REGISTRAR'S SIGNATURE: Mrs Martin J Walmsley	25. EMBALMER: Marion A. Ehlebula	LICENSE NO.: E-515

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 5177
Local Reg. No. 545
Reg. Dist. No. 360

BIRTH NO.

NOV 1 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 140 Canyon	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Melba; c. LENGTH OF STAY (In this place) minutes	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Melba
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. # 1, 000	d. STREET ADDRESS (If rural, give location) Melba

3. NAME OF DECEASED (Type or Print) a. (First) WARREN	b. (Middle) J.	c. (Last) WYLIE	4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 4, 1953	9. AGE (In years last birthday) 16; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03	10b. KIND OF BUSINESS OR INDUSTRY High School	11. BIRTHPLACE (State or foreign country) Nampa, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clark Wylie	BIRTHPLACE Ohio	14. MOTHER'S MAIDEN NAME Madge Cook	BIRTHPLACE Nebraska	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-62-5760	17. INFORMANT'S OWN SIGNATURE x Madge L. Wylie	ADDRESS Melba, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

955 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gunshot wound head -self inflicted

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE 2 (Specify) Suicide	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) In car in a field near 31	21c. (CITY, TOWN, OR TOWNSHIP) highway Near Melba 13140	(COUNTY) Canyon (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Inspection only *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* about 9.00 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Wesche 583	4 (Degree or title) M. D. Coroner	23b. ADDRESS Nampa, Idaho	23c. DATE SIGNED Nov. 14 1969
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/15/69	24c. NAME OF CEMETERY OR CREMATORY Melba Cemetery	24d. LOCATION (City, town, or county) (State) Melba, Canyon, Idaho
DATE REC'D BY LOCAL REG. Nov. 17, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Don W. Sinjiani	LICENSE NO. E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

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NOV 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5178
Local Reg. No. 556
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital (057)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Dorothy	B.	Savell	Nov. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced	Oct. 5, 1917	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
(0)		Caldwell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charley Weymouth	Minnesota	Lottie Wilson	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-07-9238	+ D J Weymouth	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 180X Cancer of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec. 13, 1967 *to* Nov. 13, 1969, *that I last saw the deceased alive on* Nov. 13, 1969, *and that death occurred at* 5:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Robert H. Jensen, M.D.	Robert H. Jensen, M.D. 222 EAST LOGAN CALDWELL, IDAHO	NOV 20 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 17, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 24, 1969	Mrs. Martin Walmsley	James R Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5179
Local Reg. No. 557
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH (141)
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital (251)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Dollie		Patrick	Nov. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		Sept. 2, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Henry, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jesse Hicks	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-36-1001A	x Marie Bishop	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1729 Malignant Melanoma — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 66, *to* Nov. 15, 19 69, *that I last saw the deceased alive on* Nov. 15 19 69 *and that death occurred at* 2:00 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert H. Jensen M.D. 258	Robert H. Jensen, M.D. 222 EAST LOGAN CALDWELL IDAHO	NOV 20 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 17, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 24, 1969	Mrs. Martine Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 1 1995

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5180
Local Reg. No. 552
Reg. Dist. No. 360

BIRTH NO. 69-11282

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Route #3 - Southside Blvd.

3. NAME OF DECEASED (Type or Print): a. (First) Robert; b. (Middle) Dan; c. (Last) Robbins

4. DATE OF DEATH (Month) (Day) (Year): November 15, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Nov. 15, 1969

9. AGE (In years last birthday): IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours: 3 / Min.: 05

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Namp, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred Robbins — BIRTHPLACE: Rigby, Idaho

14. MOTHER'S MAIDEN NAME: Irene G. Smuin — BIRTHPLACE: Idaho Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: X Fred Robbins — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Anemia — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Erythroblastosis Fetalis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

7259

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov 15, 1969, *to* Nov 15, 1969, *that I last saw the deceased alive on* Nov 15, 1969, *and that death occurred at* 8:08p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: H C Parker 163 MD (Degree or title)

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 18 Nov 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/17/1969

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Gardens

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 21, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Marvin R. Heikkila

LICENSE NO.: E-515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5181
Local Reg. No. 560
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 1 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital (05)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (145)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma
d. STREET ADDRESS (If rural, give location): Box 637

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Genevieve	R.	Watts	Nov. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	March 27, 1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
(00)		Star, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isaac Rogers	Missouri	Martha Ellen Bass	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-10-2612	x Ethel Watts	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 581 X Lipoid Nephrosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [XX] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-8-69, 19__, *to* 11-17-69, 19__, *that I last saw the deceased alive on* 11-17-69, 19__, *and that death occurred at* 7:30A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
250 W. Hubbard	222 East Elm, Caldwell, Idaho	11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov. 19, 1969	Star Cemetery	Star, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 28, 1969	Mrs. Martina Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 1 - 1969

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5182
Local Reg. No. 555
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 1 yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Star
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Sadie	Catherine	Manchester	Nov. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Nov. 26, 1890	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Phillips County, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Mc Grath	Ohio	Margaret Hollingshead	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-60-3934	F. M. Manchester	Rt. 1 Star

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 404X Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardio-Vascular Renal Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2-15, 1968, to 11-20, 1969, that I last saw the deceased alive on 11-12-, 1969, and that death occurred at 4: A m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche 583	M.D.	Nampa - Idaho	11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-24-69	Star Cemetery	Star, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 24, 1969	Mrs. Martina Walmsley	Jack H. Green	E-528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 3 1969 Bureau of Vital Statistics

State File No. 5183
Local Reg. No. 562
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (142)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gem (231)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 402 So. Hays

d. FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital (050)

3. NAME OF DECEASED (Type or Print): a. (First) Vanita; b. (Middle) Kay; c. (Last) Vanderpol

4. DATE OF DEATH: Nov. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	never married	July 13, 1956	13	4 / 7	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
child (00)	---	Emmett, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mark Vanderpol	Manson, Iowa	Veta Christison	Emmett, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	x Mark J Vanderpol	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 5692 peritonitis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) perforation rectum
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 11/19/65
19b. MAJOR FINDINGS OF OPERATION: as above
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/19, 1969, *to* 11/20, 1969, *that I last saw the deceased alive on* 11/20, 1969, *and that death occurred at* 1:30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S. C. [illegible] 524 MD	619 Canyon Nampa	11/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov. 24, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Mrs. Martina Walmsley	FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.	E-392

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5184
Local Reg. No. 558
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 26 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): WRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blvd. Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada c/o
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna
d. STREET ADDRESS (If rural, give location): Rt. # 2.

3. NAME OF DECEASED (Type or Print)
a. (First): WALTER
b. (Middle):
c. (Last): WOOD

4. DATE OF DEATH (Month) (Day) (Year): November 20, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 9, 1891

9. AGE (In years last birthday): 78
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired of

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Neeley, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph C. Wood
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Dille
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 533-30-9079A

17. INFORMANT'S OWN SIGNATURE: x Russell Wood
ADDRESS: Kuna, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4379

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebro-Vascular Insuffiency — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis — 1-2 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Bronchopneumonia with Pleural Effusion — 2½ Weeks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 11, 19 69, *to* Nov. 20, 19 69, *that I last saw the deceased alive on* Nov. 19, 19 69, *and that death occurred at* 11:40P m., *from the causes and on the date stated above.*

23a. SIGNATURE: T. Darrell Thueson, (Degree or title) M.D.

23b. ADDRESS: 1223 7th St. So. Nampa Idaho

23c. DATE SIGNED: Nov. 22, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/24/69

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Gardens

24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: Nov. 25, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Boyce Livingston

LICENSE NO.: E496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 26 1969

DEC 1 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 30 1975
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5185
Local Reg. No. 563
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051	d. STREET ADDRESS (If rural, give location) 418-So. 12th

3. NAME OF DECEASED (Type or Print) a. (First) Charlie	b. (Middle) Loyd	c. (Last) Bourland	4. DATE OF DEATH (Month) (Day) (Year) Nov. 21, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 3, 1886	9. AGE (In years last birthday) 83 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 28	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Rockwall Co., Texas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gabriel Lee Bourland	BIRTHPLACE Kentucky	14. MOTHER'S MAIDEN NAME Ruth Elizabeth Ratcliffe	BIRTHPLACE Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-28-5412A	17. INFORMANT'S OWN SIGNATURE Mrs. C. L. Bourland	ADDRESS	

7130

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pulmonary emboli	a few days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Severe osteo arthritis	indefinite
DUE TO (c)	Arterio sclerotic cardiovascular disease	indefinite
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Esophagitis	several days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* _____, 1955, *to* Nov 21, 1969, *that I last saw the deceased alive on* 11-21-, 1969, *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Chas E Kemik 280 (Degree or title) MD	23b. ADDRESS 1819 Ellis St Caldwell Idaho	23c. DATE SIGNED 11-26-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 24, 1969	24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery	24d. LOCATION (City, town, or county) (State) Caldwell, Idaho
DATE REC'D BY LOCAL REG. Dec. 2, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Rodney W. Dakan	LICENSE NO. E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5186
Local Reg. No. 559
Reg. Dist. No. 360

BIRTH NO.

RECEIVED Bureau of Vital Statistics DEC 1 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa c. LENGTH OF STAY (In this place): years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION: 619-13th Avenue South 000	d. STREET ADDRESS (If rural, give location): 619-13th Avenue South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Glaze	J.	Saulls	November 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 25, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sugar Cutter 06	Factory	Chuckey, Tennessee	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Stewart Saulls	No Record	Etta Miller	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-22-2640	Mrs Lillie M. Saulls	Nampa

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* many years *19__, to* 11-22- *, 19*69 *, that I last saw the deceased alive on* March 6 *, 19*69 *, and that death occurred at* 5 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Samuel A Cravens MD	311-14 Ave. So Nampa Idaho	11-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 25, 1969	Hillcrest Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	EMBALMER	LICENSE NO.
Nov. 28, 1969	Mrs. Martina Walmsley	Richard W. Mesenbrink	E-487

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: ALSIP FUNERAL CHAPEL

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5187
Local Reg. No. 564
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142 DEC 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Bureau of Vital Statistics
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1023 Cleveland

3. NAME OF DECEASED (Type or Print)
a. (First) Walter
b. (Middle)
c. (Last) Bradshaw

4. DATE OF DEATH (Month) (Day) (Year) Nov. 23, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Aug. 22, 1882
9. AGE (In years last birthday) 87
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mt. Vernon, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Herman Bradshaw
BIRTHPLACE Kentucky
14. MOTHER'S MAIDEN NAME Malinda Hopper
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-28-0320
17. INFORMANT'S OWN SIGNATURE x Hermia Ruckman
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Embolus
INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b) ASHD
?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-20, 1969, *to* 11-23, 1969, *that I last saw the deceased alive on* 11-23, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Graydon Olson 115 (Degree or title)
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 28 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 26, 1969
24c. NAME OF CEMETERY OR CREMATORY Weiser Cemetery
24d. LOCATION (City, town, or county) Weiser, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 3, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Rodney W. Dakan
LICENSE NO. E-508

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 0 1969
MAY 1 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5188
Local Reg. No. 585
Reg. Dist. No. 360

BIRTH NO. 69-11306

RECEIVED DEC 19 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 9 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 704 19th Ave. North

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) M. c. (Last) Howard

4. DATE OF DEATH: (Month) Nov. (Day) 23 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Nov. 23, 1969

9. AGE (In years last birthday): 0 IF UNDER 1 YR. Months: 0 Days: 0 IF UNDER 24 HRS. Hours: 9 Min.: 43

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ******* 62

10b. KIND OF BUSINESS OR INDUSTRY: ******

11. BIRTHPLACE (State or foreign country): Nampa, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rayner C. Howard
BIRTHPLACE: Texas

14. MOTHER'S MAIDEN NAME: Mary Lou Freelove
BIRTHPLACE: Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Rayner C. Howard
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Placental Insufficiency 7709
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 5:14P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Eugene M. Brown, M.D. 898 (Degree or title)
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 11/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-25-69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Canyon County, Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Glen L. Sires
LICENSE NO.: 498
FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED DEC 9 1969 Bureau of Vital

Certificate of Death

STATE OF IDAHO

State File No. 5189
Local Reg. No. 569
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place): 16da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): Box 70

3. NAME OF DECEASED (Type or Print)
a. (First): DOLORES
b. (Middle): H
c. (Last): MOLINA

4. DATE OF DEATH (Month) (Day) (Year): 11 23 69

5. SEX: F
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3/22/1933
9. AGE (In years last birthday): 36 — IF UNDER 1 YEAR: Months 8, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Salinas S.L.P. Mexico
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME BIRTHPLACE: Canuto Hernandez Pinos, Mexico
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Mariadel Refugio Salinas S. L.P

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE ADDRESS: Mexico
x Pedro Molina

18. CAUSE OF DEATH 5409
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Superior mesenteric vein thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Appendectomy & portal vein thrombosis.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 11-8-69
19b. MAJOR FINDINGS OF OPERATION: Acute appendicitis and umbilical hernia
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-7-69, *19*___, *to* 11-23-69, *19*___, *that I last saw the deceased alive on* 11-23-69, *19*___, *and that death occurred at* 6:45a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. M. Palrang, M.D. 425 [signature]
23b. ADDRESS: 227 E. Logan, Caldwell, Idaho
23c. DATE SIGNED: 12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/26/69
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Dec. 8, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 27 1988

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5190
Local Reg. No. 574
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 17 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Parkview Manor 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1711 4th. St. So.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Elizabeth	Ester	Coble	Nov. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Aug. 13, 1876	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Burlington, Ontario, Canada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Matcham	England	Mary Styles	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-14-8535T	Irene E. Fry	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Vascular Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-15, 1968, *to* 11-25, 1969, *that I last saw the deceased alive on* 10-29, 1969, *and that death occurred at* 12:45A., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
345 C Horton MD	1223-7 St. So. Nampa	11-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-28-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 9, 1969	Mrs. Martina Walmsley	Jack D. Green	528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
BIRTH NO DEC 2 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5191
Local Reg. No. 561
Reg. Dist. No. 360

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 650

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 703-9th. Ave. South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
TEALIE	F.	GALBRETH	November 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	October 27, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Sherman, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Acree	No Record	Lou Turman	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-18-4325	John F. Vincent	Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/16/ , 19 61 , *to* 11/25/ , 19 69 , *that I last saw the deceased alive on* 11/25/ , 19 69 , *and that death occurred at* 12:30 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	619 So. Canyon, Nampa, Idaho	11/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	25. EMBALMER	LICENSE NO.
No BURIAL	Nov. 28, 1969	Kohlerlawn Cemetery	Nampa, Canyon, Idaho	Richard W. Alsip	E-487

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FIRM NAME:
Dec. 1, 1969	Mrs. Martina Walmsley	Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

AUG 2 1 1970

MAY 3 1 2000

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5192
Local Reg. No. 567
Reg. Dist. No. 360

RECEIVED DEC 9 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (41)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hosp. (051)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon (41)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Indiana Street

3. NAME OF DECEASED (Type or Print): a. (First) Henry; b. (Middle) Clay; c. (Last) Ragsdale

4. DATE OF DEATH (Month) (Day) (Year): Nov. 25, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 27, 1886

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days: 11 / 27 — IF UNDER 24 HRS.: Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Upholstering (21)

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Roanoke, Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wm. P. Ragsdale — BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: Augusta Brook — BIRTHPLACE: Missippi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 515-03-3715

17. INFORMANT'S OWN SIGNATURE: x Marie Reeves, Daughter — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary — INTERVAL BETWEEN ONSET AND DEATH: 1hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) HCVD. — 10yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Asthenia — 10yr

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, *19*63, *to* Nov 25, *19*69, *that I last saw the deceased alive on* Nov 25, *19*69, *and that death occurred at* 12[3] *m., from the causes and on the date stated above.*

23a. SIGNATURE Paul E. Reynolds (437) (Degree or title) — **23b. ADDRESS** Caldwell Idaho — **23c. DATE SIGNED** Dec 5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 12-1-1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Canyon Hill Cemetery — **24d. LOCATION** (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Dec. 8, 1969 — **REGISTRAR'S SIGNATURE**: Mrs. Martina Walmsley

25. EMBALMER: Lucy M. Flahiff — **LICENSE NO.**: E-393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to MAY 4 1 1955 the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5193
Local Reg. No. 565
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 140 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place): 13 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. # 3, Nampa 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Rt. # 3,

3. NAME OF DECEASED (Type or Print): a. (First) LOUIS b. (Middle) CARVA c. (Last) HARRELSON

4. DATE OF DEATH: (Month) Nov. (Day) 26, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Dec. 17, 1906	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired c6	Machinist	Loris, So. Carolina	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
No Record	No Record	No Record	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	238-05-2858	x Mrs Lola Harrelson	Nampa, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/2/ , 19 68, *to* 11/26/ , 19 69, *that I last saw the deceased alive on* 11/26/ , 19 69 *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Elder 217 M.D.	619 So. Canyon, Nampa, Idaho	12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 1, 1969	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4, 1969	Mrs. Martin Walmsley	[signature]	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5194
Local Reg. No. 568
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Canyon — DEC 9 1969 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Parma — c. LENGTH OF STAY (in this place): 20 yr

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RFD 2 Parma

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Canyon — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Parma — d. STREET ADDRESS (If rural, give location): RFD 2 Parma

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Benjamin	Franklin	Sheat	11-26-1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	4-24-1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	Farm	Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Sheat	Kansas	Rose King	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	War 1	519-10-7963	x Elona Sheat	RFD 2 Parma Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary — INTERVAL BETWEEN ONSET AND DEATH: immed

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Chronic obst pulm disease — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-9, 1969, *to* 11-26, 1969, *that I last saw the deceased alive on* 11-26, 1969, *and that death occurred at* 8:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David M Sarazin MD 664	Nyssa Oregon	11-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-1-1969	Nyssa	Nyssa Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Dec. 8, 1969	Mrs Martina Walmsley	[illegible] Funkhouser	Nyssa Oregon

Federal Security Agency
United States Public Health Service

Form DPH-48021

DEC 18 1969

JAN 21 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of B. B. Lunkamp Lic. No. 385 at Nyssa Ore. on 11-26-69

ADDITIONAL REMARKS by Physician

Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5195
Local Reg. No. 566
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (142) DEC 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place): Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkview Manor Home 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (142)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 118- Smith St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLAY		MILLS	Nov. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Aug. 1, 1882	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 07	Farmer	Cass County, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hugh Holland Mills	Tennessee	Sarah Miller	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-26-9949	x Harry C. Mills	Route #5 Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4339

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis generalized. — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Prostatic Carcinoma. — 3 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from [illegible], 19[illegible], to Nov 30, 1969, that I last saw the deceased alive on Nov. 29, 1969 and that death occurred at 1:20 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Warren B. Foss 449 (M.D.)	Nampa Idaho	12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/3/69	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 5, 1969	Mrs. Martina Walmsley	Jerry S. Krouch	E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5196
Local Reg. No. 586
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (142)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (050)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (142)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 207 16th Ave. No.

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) A. c. (Last) Tussing

4. DATE OF DEATH (Month) (Day) (Year): 11-30-1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 3-6-1888

9. AGE (In years last birthday): 81
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (04)

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Joplin, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Tussing
BIRTHPLACE: not known

14. MOTHER'S MAIDEN NAME: Nancy Mondy
BIRTHPLACE: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-42-3923

17. INFORMANT'S OWN SIGNATURE: Nancy L. Owens
ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis with (b) hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: A.S.H.D. — 9 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/61 , 19 68 *to* 11/30/69 , 19 , *that I last saw the deceased alive on* 11/30/ , 1969 , *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE: Richard C. Owen (Degree or title) M.D.

23b. ADDRESS: 619 So. Canyon, Nampa, Idaho

23c. DATE SIGNED: 12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/3/1969

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Glen G. Irwin

LICENSE NO.: E-498

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5197
Local Reg. No. 10
Reg. Dist. No. 520-521

BIRTH NO.

NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs, Idaho
c. LENGTH OF STAY (in this place): 5½ months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou County Hospital 269

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs, Idaho
d. STREET ADDRESS (If rural, give location): 40 Mineral Heights

3. NAME OF DECEASED (Type or Print)
a. (First): Harland
b. (Middle): Victor
c. (Last): Romero

4. DATE OF DEATH (Month) (Day) (Year): Nov. 10, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Aug. 27, 1907
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Care of Heavy Equip. 11
10b. KIND OF BUSINESS OR INDUSTRY: Road Construction
11. BIRTHPLACE (State or foreign country): Mt. Pleasant, Utah
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Andrew Romero — BIRTHPLACE: Fairview, Utah
14. MOTHER'S MAIDEN NAME: Hannah Mortensen — BIRTHPLACE: Mt. Pleasant, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-01-3945
17. INFORMANT'S OWN SIGNATURE: Faunda Bybee — ADDRESS: Soda

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

428X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1969, *to* Nov 9, 1969, *that I last saw the deceased alive on* Nov 9, 1969, *and that death occurred at* 11:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Lumer Tigert 535 (Degree or title) MD.
23b. ADDRESS: Soda Springs Idaho
23c. DATE SIGNED: 11/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: 11-24-69
REGISTRAR'S SIGNATURE: Norene Brunn
25. EMBALMER: Nile Matthews — LICENSE NO.: E 359

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Whitman-Matthews Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5198
Local Reg. No. 11
Reg. Dist. No. 520-521

Certificate of Death

BIRTH NO. 69-11330 RECEIVED STATE OF IDAHO

DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
c. LENGTH OF (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou Mem. Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Utah 45
b. COUNTY Salt Lake 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salt Lake City
d. STREET ADDRESS (If rural, give location) 278 West 6th North

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last) Troy Wallace Henderson

4. DATE OF DEATH (Month) (Day) (Year) Nov. 20, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant
8. DATE OF BIRTH Nov. 20, 1969
9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR Months 0 Days 0 — IF UNDER 24 HRS. Hours 7 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Soda Springs, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Raymond Rivera — BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Cheri Storrs — BIRTHPLACE Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs. Clera Homer — ADDRESS Soda Springs, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 7½ hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-20, 1969, *to* 11-20, 1969, *that I last saw the deceased alive on* 11-20, 1969, *and that death occurred at* 1:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Russell Tigert 535 (Degree or title) MD
23b. ADDRESS Soda Springs Ida
23c. DATE SIGNED 12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/22/69
24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery
24d. LOCATION (City, town, or county) (State) Soda Springs, Idaho

DATE REC'D BY LOCAL REG. 12-16-69
REGISTRAR'S SIGNATURE Norene Bunn
25. EMBALMER Theodore S Allen
LICENSE NO. E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5199
Local Reg. No. 2046
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 15 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burley Nursing Home 290

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Declo - rural
d. STREET ADDRESS (If rural, give location): 1 Mi. No. 3/4 Mi. W.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Eva	Sofia	Peterson	Oct. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
female	White	Never Married	Feb. 15, 1889	80	8	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home 01		Salt Lake City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter August Peterson	Sweden	Emma Sophrona Carlson,	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— — —	518-60-8884	Peter A. Peterson	Declo

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia, suspected	1-2 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Amyotroph.c Lat. sclerosis	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1966, *to* Oct. 29, 1969, *that I last saw the deceased alive on* March, 1969, *and that death occurred at* 5:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. N. Arnold MD	Burley, Idaho	11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
burial	Nov. 1, 1969	Declo Cemetery	Declo,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21 1969	Bess N. Pearson	Ormand F. Burch	E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5200
Local Reg. No. 2048
Reg. Dist. No. 470

BIRTH NO.

RECEIVED NOV 28 1969 Bureau of Vital

1. PLACE OF DEATH
a. COUNTY Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (In this place) 1 hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Arizona 03
b. COUNTY Gila 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Globe
d. STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Leo	Donald	Hood	November 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Indian	married	March 7, 1941	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	College	Rehoboth, New Mexico	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dan Hood	Gallup, New Mexico	Mae Hunter	Manuelito, New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Viet Nam 7	525-98-7112	Mrs. Jo Ann Hood	

965 X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gunshot wound, abdominal aorta with exsanguination — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11-2-69	Exsanguination from abdominal aorta gunshot wound	Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
3 Homicide	31	Burley 13160	Cassia	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK	NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
11-	1-	69	m.	[ ]	[X]	Gunshot wound

22. I hereby certify that I attended the deceased from November 1, 1969, to November 1, 1969, that I last saw the deceased alive on 11-1, 1969, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C Hayden Ellingham 636	M.D.	2233 Overland Avenue; Burley	11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/5/69	Pleasant View Cem.	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 25, 1969	Bill A. Pearson	Jerry K. Lawson	E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5201
Local Reg. No. 2045
Reg. Dist. No. 470

BIRTH NO.

RECEIVED NOV 13 1969 Vital Statistics Bureau

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
LENGTH OF STAY (in this place): Lifetime
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 9 miles north 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley - rural
d. STREET ADDRESS (If rural, give location): 1½ Mi. West 1 Mi. North

3. NAME OF DECEASED (Type or Print): a. (First) Horton b. (Middle) Edwin c. (Last) Mabey

4. DATE OF DEATH: (Month) Nov. (Day) 5, (Year) 1969

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 24, 1900

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR Months: 9 Days: 12
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oakley, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John James Mabey, BIRTHPLACE: Dorsetshire, England

14. MOTHER'S MAIDEN NAME: Danieletta Wood, BIRTHPLACE: Bountiful, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 518-12-7871

17. INFORMANT'S OWN SIGNATURE: Eva Mabey ADDRESS: Oakley, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Heart attack — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis General
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hepatitis - Chronic

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April 3, 1968, *to* Nov 5, 1969, *that I last saw the deceased alive on* Nov 3, 1969, *and that death occurred at* 2:40 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward A Rees M.D. 431
23b. ADDRESS: Twin Falls Idaho
23c. DATE SIGNED: 11-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Oakley Cemetery
24d. LOCATION (City, town, or county) (State): Oakley, Idaho

DATE REC'D BY LOCAL REG.: Nov 12, 1969
REGISTRAR'S SIGNATURE: Beth A. Pearson
25. EMBALMER: Armand J Burch
LICENSE NO.: E-471
FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 28 1969 Vital Statistics Bureau of Health

State File No. 5202
Local Reg. No. 2050
Reg. Dist. No. 470

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (In this place): Years
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: 710 West 21st Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 710 West 21st Street

3. NAME OF DECEASED (Type or Print)
a. (First): Wilhelm
b. (Middle): (Willy)
c. (Last): Juli

4. DATE OF DEATH (Month) (Day) (Year): Nov. 10, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 8, 1904

9. AGE (In years last birthday): 64
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Chef 21

10b. KIND OF BUSINESS OR INDUSTRY: Resturant

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 524-38-5562

17. INFORMANT'S OWN SIGNATURE: Info obtained from deceased personal effects.
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Probable acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Acute coronary artery occlusion — sudden
DUE TO (c): Arteriosclerotic cardiovascular disease with chronic myocardial failure

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-4-69, 19____, *to* 11-10-69, 19____, *that I last saw the deceased alive on* 11-10-69, 19____, *and that death occurred at* 9:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Snow Bldg. Burley, Idaho

23c. DATE SIGNED: 11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 11/14/69

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Nov. 25, 1969

REGISTRAR'S SIGNATURE: Buck H. Pearson

25. EMBALMER: [signature]

LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 2 1 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5203
Local Reg. No. 2047
Reg. Dist. No. 470

BIRTH NO.

NOV 24 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Cassia 161	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: California 05 b. COUNTY: San Mateo 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley; c. LENGTH OF STAY (If in place): one Day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): South San Francisco
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070	d. STREET ADDRESS (If rural, give location): 366 Valencia Drive

3. NAME OF DECEASED (Type or Print) a. (First): Effie	b. (Middle): Verness	c. (Last): Larson	4. DATE OF DEATH (Month) (Day) (Year): Nov. 10, 1969		
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: May 24, 1915	9. AGE (In years last birthday): 54	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 61	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Oakley, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Orson C. Richins	BIRTHPLACE: Grouse Creek, Utah	14. MOTHER'S MAIDEN NAME: Mabel Hunter	BIRTHPLACE: Oakley, Idaho		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no	(If yes, give war or dates of service): none	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: × Daniel P. Larson	ADDRESS: S. San Francisco Calif.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Metastatic Carcinoma of the breast

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
~~Conditions contributing to the death but not related to the disease or condition causing death.~~ Upper gastro-intestinal hemorrhage secondary to cortisone therapy.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 11-8, 1969, *to* 11-10, 1969, *that I last saw the deceased alive on* 11-10, 1969 *and that death occurred at* 300 *m. from the causes and on the date stated above.*

23a. SIGNATURE: Samuel J. Hammond (Degree or title) 647	23b. ADDRESS: Box 47 Paul Idaho	23c. DATE SIGNED: 11/17/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 11/13/69	24c. NAME OF CEMETERY OR CREMATORY: Oakley Cemetery	24d. LOCATION (City, town, or county) (State): Oakley, Idaho
DATE REC'D BY LOCAL REG.: Nov. 21 1969	REGISTRAR'S SIGNATURE: Beth H. Pearson	25. EMBALMER: [signature]	LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 25 1969

DEC 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 28 1969 Bureau of Vital Statistics

State File No. 5204
Local Reg. No. 2049
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (In this place) 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3631 Overland Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 3631 Overland Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Truth
b. (Middle) Cecelia
c. (Last) Egley

4. DATE OF DEATH (Month) (Day) (Year) Nov. 16, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Oct. 14, 1917
9. AGE (In years last birthday) 52 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Arthur D. James BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Myrtle A. Walter BIRTHPLACE Oakley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) * * *
16. SOCIAL SECURITY NO. 519-28-6118
17. INFORMANT'S OWN SIGNATURE Wallace R. Egley ADDRESS Burley

18. CAUSE OF DEATH 1579
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of pancreas with

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) extensive metastatic disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1969, *to* Nov 16, 1969, *that I last saw the deceased alive on* Nov 16, 1969, *and that death occurred at* 4:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Russella Newark 881 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 18 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 29, 1969
24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cem.
24d. LOCATION (City, town, or county) (State) Burley, Idaho

DATE REC'D BY LOCAL REG. Nov. 25, 1969
REGISTRAR'S SIGNATURE Bert H. Pearson
25. EMBALMER Jerry K. Lawson
LICENSE NO. E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 1969

AUG 2 3 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5205
Local Reg. No. 2050
Reg. Dist. No. 470

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Cassia (60)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) R.F.D.
c. LENGTH OF STAY (In this place) None

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 1526 Normal Ave.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Near Cottrel Port of Entry (000)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Willis	Howard	Wilkinson	Nov. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	Divorced	Aug. 22, 1924	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Resturant Owner 22	Resturant	Gooding, Idaho	U.S.A.

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
Horace Wilkinson- Hoytsville, Utah	Eliza Jensen - Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes W.W. # 2	518-22-7387	X Patricia Wilkinson	Burley, Ida.

2129

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Severely crushed chest & head injuries received in a two

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) automobile collision
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Instant

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Hiway 06	Rural (3/60)	Cassia	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
11-20-69 Abt 4:p m.		Collision, automobile

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* Abt 4:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L.B. Young 583 Coroner	Burley, Idaho	11-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/24/69	Pleasant View	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Rick N. Pearson	Smith Payne	E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

JAN 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 5 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

MAY 4 1979

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5206
Local Reg. No. 69
Reg. Dist. No. 210

Certificate of Death

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Headquarters-rural
c. LIMITS OF STAY (in this place): days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Camp C 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural
d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print)
a. (First): LLOYD
b. (Middle): L.
c. (Last): MOORE

4. DATE OF DEATH (Month) (Day) (Year): Nov. 1, 1969

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 3, 1925
9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): woods worker 17
10b. KIND OF BUSINESS OR INDUSTRY: lumber
11. BIRTHPLACE (State or foreign country): Neosho, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Martin L. Moore — BIRTHPLACE: Mo.
14. MOTHER'S MAIDEN NAME: X Susie Hodges — BIRTHPLACE: unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.: 519-18-3507
17. INFORMANT'S OWN SIGNATURE: Geraldine L Moore — ADDRESS: Orofino

4/69

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 11:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 4 (Degree or title): Coroner
23b. ADDRESS: Route 1, Orofino, Idaho
23c. DATE SIGNED: 11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 5, 69
24c. NAME OF CEMETERY OR CREMATORY: Wells Bench
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Nov. 6, 1969
REGISTRAR'S SIGNATURE: Lorn M. Burger
25. EMBALMER: [signature] — LICENSE NO.: 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 20 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 25 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 26 1969

FEB 20 1976

OCT 24 1988

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 10 1969 Bureau of Vital Statistics

State File No. 5207
Local Reg. No. 70
Reg. Dist. No. 210

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater (180)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
STAY (in this place): 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. (073)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater (180)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Southwick-rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BYRA	A.	KITE	Nov. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	married	Jan. 21, 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (00)
10b. KIND OF BUSINESS OR INDUSTRY: petrolium
11. BIRTHPLACE (State or foreign country): Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Kite — BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Sarah Mills — BIRTHPLACE: Ky.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 555-09-9281
17. INFORMANT'S OWN SIGNATURE: X Frieda B. Kite — ADDRESS: Southwick

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic CA — INTERVAL BETWEEN ONSET AND DEATH: 3-4 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death ASHD, emphysema — yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1926, *to* 11-4, 1969, *that I last saw the deceased alive on* 11-4, 1969 *and that death occurred at* 11:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] (038)
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: 11-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 8, 69
24c. NAME OF CEMETERY OR CREMATORY: Union Cem.
24d. LOCATION (City, town, or county) (State): Bakersfield, Kern, Calif.

DATE REC'D BY LOCAL REG.: Nov. 6, 1969
REGISTRAR'S SIGNATURE: Vern M. Burger
25. EMBALMER: Lyle A. Gutmann
LICENSE NO.: 476
FIRM NAME: Gilbert's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

NOV 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 19 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended December 1, 1969

Certificate of Death
STATE OF IDAHO

State File No. 5208
Local Reg. No. 210
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elk River
c. LENGTH OF STAY (In this place): 8 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elk River
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print): a. (First) Manford; b. (Middle) L.; c. (Last) Parsley
4. DATE OF DEATH (Month) (Day) (Year): November 4, 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: May 30, 1939
9. AGE (In years last birthday): 30 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: David R. Parsley — BIRTHPLACE: Lewiston, Idaho
14. MOTHER'S MAIDEN NAME: Lola Austin — BIRTHPLACE: Flora, Oregon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-42-0074
17. INFORMANT'S OWN SIGNATURE: David Parsley — ADDRESS: Elk River, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 916X Crushed skull & Chest — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Log falling from truck
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Elk River, Idaho09
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Elk River 13180 Clearwater Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 4, 1969 4p m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Hit by log falling from truck

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Wm. F. Shields, Coroner (Degree or title) 583
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: 11-10-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington
DATE REC'D BY LOCAL REG.: Nov 10, 1969
REGISTRAR'S SIGNATURE: Fern M. Burger
25. EMBALMER: W. C. Merchant
LICENSE NO.: FD 5

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Merchant Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED
DEC 1 1969
Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Washington } ss.
County of Asotin }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Manfred L. Parsley (Name on Original Certificate) who died (Was Born or Died) on Nov 4, 1969 (Date of Event)
in Clearwater County, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date) are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#3 Name of deceased	Manfred L. Parsley	Manford L. Parsley
#8 Date of Birth	May 30, 1936 - age 33	May 30, 1939 - age 30
#16 social security no	None	518-42-0074

Subscribed and sworn to before me this 30 day of November, 1969

Notary Public, residing at Clarkston

My commission expires 12-22-71

(Seal)

Signed W C Merchant
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

P O Box 107-Clarkston, Wa 99403
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Washington } ss.
County of Asotin }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 30 day of November, 1969

Notary Public, residing at Clarkston

My commission expires 12-22-71

(Seal)

Signed Robert Lawler
(Signature of Any Credible Person)

P O Box 165-Clarkston, Wash 99403
(Street Address, City, State)

FORM DH 60-155

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED NOV 17 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No.
Local Reg. No. 71
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CLEARWATER
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ELK RIVER
c. LENGTH OF STAY (Institutions): 8 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CLEARWATER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ELK RIVER
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print)
a. (First): MANFRED
b. (Middle): L.
c. (Last): PARSLEY

4. DATE OF DEATH (Month) (Day) (Year): NOV. 4, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: May 30, 1936
9. AGE (In years last birthday): 33 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David R. Parsley — BIRTHPLACE: Lewiston, Idaho
14. MOTHER'S MAIDEN NAME: Lola Austin — BIRTHPLACE: Flora, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S OWN SIGNATURE: David Parsley — ADDRESS: ELK RIVER IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushed skull & chest — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Log falling from truck
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Elk River, Idaho
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Elk River Clearwater Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11 4 69 4:P m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Hit by log falling from truck

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] — (Degree or title): Coroner
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: 11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: NOV 7, 1969
24c. NAME OF CEMETERY OR CREMATORY: VINELAND CEMETERY
24d. LOCATION (City, town, or county) (State): CLARKSTON, WASHINGTON

DATE REC'D BY LOCAL REG.: Nov. 10, 1969
REGISTRAR'S SIGNATURE: Fern M. Burger
25. EMBALMER: W C Merchant
LICENSE NO.: FD 5

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Merchant Funeral Home

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 1 1969

DEC 2 1969

APR 2 6 1974

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5209
Local Reg. No. 72
Reg. Dist. No. 210

RECEIVED NOV 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater (180)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Headquarters-rural
LENGTH OF STAY (In this place) hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) (22)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater (180)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pierce-rural
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DANIEL	DREW	HALL	Nov. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	never married	Oct. 18, 1953	16				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student (03)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hanford, Calif.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jack E. Hall — BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Norma Meadows — BIRTHPLACE Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 543-64-6036
17. INFORMANT'S OWN SIGNATURE Rev. Jack E. Hall — ADDRESS Pierce

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Strangulation — INTERVAL BETWEEN ONSET AND DEATH: Seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) becoming entangled in branches of fallen tree.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Lost while hunting - Panic - Exposure - exhaustion.
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) in forest (12)
21c. (CITY, TOWN, OR TOWNSHIP) (13/80) (COUNTY) (STATE) Headquarters, Clearwater, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 5, 69 P.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Entangled in tree branches.

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Coroner (583) (4)
23b. ADDRESS Orofino, Idaho
23c. DATE SIGNED Nov. 10,69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial (3)
24b. DATE Nov. 12, 69
24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.
24d. LOCATION (City, town, or county) (State) Laton, Kings Co., Calif.

DATE REC'D BY LOCAL REG. Nov. 10, 1969
REGISTRAR'S SIGNATURE Fern M. Burger
25. EMBALMER
LICENSE NO. 476
FIRM NAME: Gilbert's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5210
Local Reg. No. 77
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): ANNA
b. (Middle): ETHEL
c. (Last): WESTERDALE

4. DATE OF DEATH (Month) (Day) (Year): Nov. 8, 1969

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov. 11, 1886
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Cambridge, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: E. R. Chandler — BIRTHPLACE: Unk.
14. MOTHER'S MAIDEN NAME: Unk. — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT'S OWN SIGNATURE: X A. M. Westerdale — ADDRESS: Orofino

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): ASHD — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Fx hip — 1 wk

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1966, *to* Nov, 1969 *that I last saw the deceased alive on* Nov 8, 1969, *and that death occurred at* 5:54 p m, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 038 [signature]
23b. ADDRESS: Orofino
23c. DATE SIGNED: 11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 13, 69
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Nov. 21, 1969
REGISTRAR'S SIGNATURE: Fern M. Burger
25. EMBALMER: [signature]
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5211
Local Reg. No. 75
Reg. Dist. No. 210

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY (180) Clearwater

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino - rural

c. LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Miles N.E. on North Fork (080)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY Clearwater (180)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pierce - rural

d. STREET ADDRESS (If rural, give location) at Larson's Bar

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Richard	Allen	Rawson	Nov.	10	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	never married	Sept. 13, 1966	3				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
(02)		Spokane Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Stephen Rawson	Elk River, Idaho	Sandra Squires	Grangeville, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Karl Brandt	Kooskia Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) drowning

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (13180) (COUNTY) (STATE)
accident	river (06)	Headquarters, Clwtr., Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Nov. 10, 69 2 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	auto left roadway & entered river

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	Orofino, Idaho	11-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 14, 1969	Pine Grove Cem.	Kooskia Idaho Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 14, 1969	Vern M. Burger	[signature]	476

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5212
Local Reg. No. 74
Reg. Dist. No. 210

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater (180)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino - rural
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Miles N.E. on North Fork ooo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater (180)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pierce - rural
d. STREET ADDRESS (If rural, give location) at Larson's Bar

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Sandra	Elaine	Rawson	Nov.	10	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	white	married	March 17, 1950	19				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wife - Mother	Own home	Grangeville, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oran E. Squires	Kansas	Norma A. Brandt	Cloquet, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Karl Brandt	Kooskia, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) drowning

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) river 06

21c. (CITY, TOWN, OR TOWNSHIP) 13180 (COUNTY) (STATE) Headquarters-rural, Clwtr., Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 10, 69 2 p.m

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? auto left roadway & entered river

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 583	coroner	Orofino, Idaho	11-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 14 1969	Pine Grove Cem.	Kooskia Idaho, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 14, 1969	Vern M. Burger	[signature]	476

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5213
Local Reg. No. 73
Reg. Dist. No. 210

RECEIVED NOV 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater (180)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino - rural
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 miles N.E. on North Fork (180)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater (180)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pierce - rural
d. STREET ADDRESS (If rural, give location) at Larson's Bar

3. NAME OF DECEASED (Type or Print) a. (First) Teana b. (Middle) Marie c. (Last) Rawson

4. DATE OF DEATH (Month) Nov. (Day) 10 (Year) 1969

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH January 25 1968

9. AGE (In years last birthday) 1 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Lewiston Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Stephen Rawson BIRTHPLACE Elk River, Idaho

14. MOTHER'S MAIDEN NAME Norma A Brandt (Karl Brandt) BIRTHPLACE Cloquet Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Kooskia ADDRESS Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) drowning
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) river 06

21c. (CITY, TOWN, OR TOWNSHIP) Headquarters-rural, Clwtr., (COUNTY) (STATE) Idaho (13180)

21d. TIME OF INJURY (Month) Nov. (Day) 10, (Year) 69 (Hour) 2 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? auto left roadway & entered river

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (583) (Degree or title) coroner

23b. ADDRESS Orofino, Idaho

23c. DATE SIGNED 11-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 14 1969

24c. NAME OF CEMETERY OR CREMATORY Pine Grove

24d. LOCATION (City, town, or county) Kooskia Idaho (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 14, 1969

REGISTRAR'S SIGNATURE Jerd M. Burger

25. EMBALMER [signature] LICENSE NO. 476

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5214
Local Reg. No. 78
Reg. Dist. No. 210

BIRTH NO.

RECEIVED NOV 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN Weippe
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) own home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clwtr. 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weippe-rural
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE
b. (Middle) RAYMOND
c. (Last) SIMON

4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1969

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Unknown

9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanich-welder 17

10b. KIND OF BUSINESS OR INDUSTRY lumber mill

11. BIRTHPLACE (State or foreign country) Canton, Ill.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Barney Simon
BIRTHPLACE unk.

14. MOTHER'S MAIDEN NAME Catherine Thomas
BIRTHPLACE Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 331-01-0219

17. INFORMANT'S OWN SIGNATURE X Mrs. George B. Simon
ADDRESS Weippe

18. CAUSE OF DEATH 4189
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* unkn. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 583 4

23b. ADDRESS Orofino, Idaho

23c. DATE SIGNED 11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 17, 69

24c. NAME OF CEMETERY OR CREMATORY Weippe Cem.

24d. LOCATION (City, town, or county) (State) Weippe Ida o

DATE REC'D BY LOCAL REG. Nov. 21, 1969

REGISTRAR'S SIGNATURE Lirn M. Burger

25. EMBALMER [signature]

LICENSE NO. 476

FIRM NAME: Gilbert's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5215
Local Reg. No. 76
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CLEARWATER 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): OROFINO
c. LENGTH OF STAY (in this place): 4 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: BONNER 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): OWEN
c. (Last): BEEMAN

4. DATE OF DEATH (Month) (Day) (Year): 11 15 69

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: September 1, 1899
9. AGE (In years last birthday): 70 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired 28
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carmon, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Martindale Beeman — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Annie May Tiffany — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WWI 3
16. SOCIAL SECURITY NO.: 556 05 4117
17. INFORMANT'S OWN SIGNATURE: Evelyn Olson — ADDRESS: Medical Records, SHN, Box 672, Orofino, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hepatic decompensation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — Prob. Toxic?

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Chronic Cirrhosis, mild

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 10/31/69
19b. MAJOR FINDINGS OF OPERATION: Obstruction common bile duct; gastric ulcer
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 18, 19 69, *to* Nov. 15, 19 69, *that I last saw the deceased alive on* 11/14, 19 69, *and that death occurred at* 12:40am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Constancio A. Cleto, M.D. — C. A. Cleto, M.D. 595
23b. ADDRESS: Box 672, Orofino, Idaho
23c. DATE SIGNED: 11/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Nov. 18, 69
24c. NAME OF CEMETERY OR CREMATORY: Wilson Kratzer Mort.
24d. LOCATION (City, town, or county) (State): Richmond, Contra Costa Calif.

DATE REC'D BY LOCAL REG.: Nov. 17, 1969
REGISTRAR'S SIGNATURE: Fern M. Burger
25. EMBALMER: [signature]
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5216
Local Reg. No. 80
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Greer
c. LENGTH OF STAY (In this place) 1½ yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Arcadian Nursing Home 075

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Frank
b. (Middle)
c. (Last) McArthur

4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1969

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH April 2, 1885
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labarer 06
10b. KIND OF BUSINESS OR INDUSTRY unk.
11. BIRTHPLACE (State or foreign country) Minn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Devin McArthur — BIRTHPLACE Unk
14. MOTHER'S MAIDEN NAME Unk. — BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-60-9867
17. INFORMANT'S OWN SIGNATURE Lyle A. Strottmann — ADDRESS Orofino

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14, 1969, *to* 11-15, 1969, *that I last saw the deceased alive on* 11-15, 1969, *and that death occurred at* 4:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert D. Hill, M.D. 490 (Degree or title)
23b. ADDRESS Orofino Idaho
23c. DATE SIGNED 11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 26, 1969
24c. NAME OF CEMETERY OR CREMATORY Riverside
24d. LOCATION (City, town, or county) (State) Orofino, Idaho

DATE REC'D BY LOCAL REG. Nov. 21, 1969
REGISTRAR'S SIGNATURE Fern M. Burger
25. EMBALMER Lyle A. Strottmann — LICENSE NO. 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5217
Local Reg. No. 79
Reg. Dist. No. 210

BIRTH NO.

RECEIVED NOV 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (In this place): 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ROY
b. (Middle): E.
c. (Last): SNYDER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 15, 1969

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Mar. 14, 1916
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: repair
11. BIRTHPLACE (State or foreign country): Weippe, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Woward Snyder — BIRTHPLACE: W. Va.
14. MOTHER'S MAIDEN NAME: Minnie Bonner — BIRTHPLACE: W. Va.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.: 518-03-7821
17. INFORMANT'S OWN SIGNATURE: X Joyce Buchholz — ADDRESS: Weippe Ida

4189

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 5 HRS

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): ASHD — 8 MO
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-14, 1969, *to* 11-15, 1969, *that I last saw the deceased alive on* 11-15, 1969 *and that death occurred at* 11 45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 430 C A Reber MD
23b. ADDRESS: Orofino Idaho
23c. DATE SIGNED: 11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 18, 69
24c. NAME OF CEMETERY OR CREMATORY: Weippe
24d. LOCATION (City, town, or county) (State): Weippe, Idaho

DATE REC'D BY LOCAL REG.: Nov. 21, 1969
REGISTRAR'S SIGNATURE: Fern M. Burger
25. EMBALMER: Lyle A. Strottmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

NOV 26 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5218
Local Reg. No. 81
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural
c. LENGTH OF STAY (In this place): 5 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harmony Hghts Rst Hm 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ahsahka
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Thomas
b. (Middle): R.
c. (Last): Walker

4. DATE OF DEATH (Month) (Day) (Year): Nov. 17, 1969

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Sept. 22, 1881
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Erie Co. N. Y.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Walker — BIRTHPLACE: Unk.
14. MOTHER'S MAIDEN NAME: Josephine La Chard — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-20-6402
17. INFORMANT'S OWN SIGNATURE: X Selma J. Dodge — ADDRESS: Ahsahka

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): CVA — INTERVAL BETWEEN ONSET AND DEATH: few hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Gen. arteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: ASHD — years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Nov 17, 1969, *that I last saw the deceased alive on* Nov 3, 1969 *and that death occurred at* 10:45 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 038
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: 11-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 21, 69
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Nov. 21, 1969
REGISTRAR'S SIGNATURE: Fern M. Burger
25. EMBALMER: [signature]
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 5 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5219
Local Reg. No. 82
Reg. Dist. No. 210

Certificate of Death

RECEIVED
DEC 8 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pierce-rural
c. LENGTH OF STAY (In this place): unk.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jaype Log Yard 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pierce-rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): GRACE
b. (Middle): MARIE
c. (Last): PACKARD

4. DATE OF DEATH (Month) (Day) (Year): Nov. 20, 1969

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 2, 1920
9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Cottonwood, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James N. Bledsoe — BIRTHPLACE: N. C.
14. MOTHER'S MAIDEN NAME: Unk. — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: unk.
17. INFORMANT'S OWN SIGNATURE: X Walter R. Packard — ADDRESS: Pierce

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): gunshot wound to head — INTERVAL BETWEEN ONSET AND DEATH: sec.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 2 suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): factory 31
21c. (CITY, TOWN, OR TOWNSHIP) 13 180 (COUNTY) (STATE): Pierce, Clearwater, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 20, 69, 7:30a
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 4 (Degree or title): coroner
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: 12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 25, 69
24c. NAME OF CEMETERY OR CREMATORY: Pierce
24d. LOCATION (City, town, or county) (State): Pierce, Idaho

DATE REC'D BY LOCAL REG.: Dec. 5, 1969
REGISTRAR'S SIGNATURE: Lern M. Burger
25. EMBALMER: Ly C. A. Strottmann — LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5220
Local Reg. No. 83
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 8 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino-rural
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print)
a. (First) ALFRED
b. (Middle) H.
c. (Last) SNYDER

4. DATE OF DEATH (Month) (Day) (Year) Nov. 23, 1969

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Feb. 23, 1911
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) logger 17
10b. KIND OF BUSINESS OR INDUSTRY lumber
11. BIRTHPLACE (State or foreign country) Orofino, Idaho
12. CITIZEN OF WHAT COUNTRY? Idaho

13. FATHER'S NAME Amos Snyder — BIRTHPLACE W. Va.
14. MOTHER'S MAIDEN NAME Betty Ladd — BIRTHPLACE Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-03-5167
17. INFORMANT'S OWN SIGNATURE X Elizabeth S. Snyder — ADDRESS Orofino

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Congestive failure, Cardiac

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia
DUE TO (c) Pulmonary Emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Asthma.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to* 23 Nov, 1969, *that I last saw the deceased alive on* 23 Nov, 1969, *and that death occurred at* 3:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Marie Cumber M.D. 340
23b. ADDRESS Orofino, Idaho
23c. DATE SIGNED 30 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 25, 69
24c. NAME OF CEMETERY OR CREMATORY Weseman
24d. LOCATION (City, town, or county) (State) Orofino, Idaho

DATE REC'D BY LOCAL REG. Dec. 5, 1969
REGISTRAR'S SIGNATURE Fern M. Burger
25. EMBALMER Lyle A. Strottmann
LICENSE NO. 476

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5221
Local Reg. No. 84
Reg. Dist. No. 210

BIRTH NO.

RECEIVED DEC 8 1969 Vital Statistics Bureau of Idaho

1. PLACE OF DEATH
a. COUNTY Clearwater (80)
b. CITY OR TOWN Orofino
c. LENGTH OF STAY (in this place) D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA Clwr. Valley Hosp. (073)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater (180)
c. CITY OR TOWN Orofino-rural
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ROSS	ERNEST	SAXTON	Nov. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	married	Aug. 15, 1921	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
master mechanic //	construction	Smithfield, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph E. Saxton	Utah	Myrtle E. Rowe	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW 2	519-14-9355	John R. Saxton	Lewiston, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: sec.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] (83)	Coroner	Orofino, Idaho	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial (3)	Dec. 2, 69	Normal Hill	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 5, 1969	Vern M. Burger	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 16 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUN 2 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5222
Local Reg. No. 75
Reg. Dist. No. 380 391

BIRTH NO.

NOV 20 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): Mountain Home Hotel

3. NAME OF DECEASED (Type or Print): a. (First) CHARLEY; b. (Middle) LEE; c. (Last) THOMPSON

4. DATE OF DEATH (Month) (Day) (Year): Nov. 1, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: July 13, 1900

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Horton, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Peter I. Thompson
BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Anna May Campbell
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-01-4564

17. INFORMANT'S OWN SIGNATURE: Elmore Mem. Hospital Records, Mt. Home
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Complete pump failure
INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Acute Myocardial Infarction
DUE TO (c): Coronary artery disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Howard M. Weller M.D. 623
23b. ADDRESS: 890 N 6th East Mt Home
23c. DATE SIGNED: 11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/4/69
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Nov 17 1969
REGISTRAR'S SIGNATURE: C Andersen
25. EMBALMER: A. Neil Humphreys
LICENSE NO.: E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: NOV 20 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 20 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5223
Local Reg. No. 76
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
LENGTH OF STAY (in this place) 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Nursing Home 356

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
d. STREET ADDRESS (If rural, give location) Elmore Memorial Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First) ARCHIE b. (Middle) c. (Last) KIMBALL

4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH May 18, 1883

9. AGE (In years last birthday) 86
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 28

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Apoleton, Minnesota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Clarence Kimball
BIRTHPLACE Maine

14. MOTHER'S MAIDEN NAME Ida Thomkins
BIRTHPLACE New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 475-07-2462A

17. INFORMANT'S OWN SIGNATURE Elmore Memorial Nursing Home,
ADDRESS Mtn. Hom

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 792X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Donna L Beel M82 (Degree or title)

23b. ADDRESS Mountain Home, Idaho

23c. DATE SIGNED 11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/6/69

24c. NAME OF CEMETERY OR CREMATORY Mtn. View Cemetery

24d. LOCATION (City, town, or county) (State) Mountain Home, Idaho

DATE REC'D BY LOCAL REG. Nov 17 1969

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER [signature]

LICENSE NO. E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5224
Local Reg. No.
Reg. Dist. No.

RECEIVED
NOV 14 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - King Hill
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2½ miles So. of King Hill

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - King Hill
d. STREET ADDRESS (If rural, give location): 2½ miles So. of King Hill

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LAMBERT	CLARENCE	KING	November 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Sept. 13, 1905	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Businessman	Laundry	Alliance, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lambert King		Katherine Landrigan	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-07-5718	Richard C King	Glenns Ferry, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 16 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 27, 1969, *to* Nov 5, 1969, *that I last saw the deceased alive on* Nov 4, 1969, *and that death occurred at* 6 00 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wendell Rubien	MD	Box 70 Glenns Ferry Idaho	Nov 12, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/8/59	Glenn Rest Cemetery	Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 12-1969	Mary Sullivan	Arthur Smith	E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 2 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5225
Local Reg. No. 77
Reg. Dist. No. 380 391

RECEIVED NOV 20 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Mem. Nursing Home 356

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
d. STREET ADDRESS (If rural, give location) Elmore Memorial Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MRS.	HATTIE	HENDRICKS HANEY	November 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Oct. 30, 1876	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 0/	own home	Quedlinburg, Saxony, Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christian Hendricks	Germany	Luisa Hoffmeister	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Hattie Bell Rose	Eagle Butte, S.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) immobilization

DUE TO (c) Fracture of hip

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-3-69	Hip pinning for fracture of hip	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
10	1	69	m.		Fall

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donna L. Bell 782 MD	Mountain Home, Idaho	11/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/11/69	Mtn. View Cemetery	Mtn. Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 17 1969	[signature]	[signature]	E-502

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
DEC 1 1 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5226
Local Reg. No. 80
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Featherville
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 12 East Featherville - Ranch

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Featherville
d. STREET ADDRESS (If rural, give location): 12 East of Featherville

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MRS.	KATHERINE O'DANIEL	HUGHES	November 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	August 4, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Rocky Bar, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas O'Daniels	Missouri	Mary Ayres	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Bruce Hughes	da. Featherville,

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3959

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congestive heart failure	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arrhythmia type heart beat of unknown cause	
DUE TO (c)	Aortic stenosis	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did not see alive, 19 ___, *that I last saw the deceased alive on* ___, 19 ___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur Smith 583	CORONER	MTN. HOME, IDAHO	11/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/17/69	Mtn. View Cemetery	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 1 1969	[illegible] Anderson	[illegible] Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

BIRTH NO. 69-11394 130

RECEIVED Certificate of Death

STATE OF IDAHO

DEC 1 1969

Bureau of Vital Statistics

State File No. 5227
Local Reg. No. 81
Reg. Dist. No. 380 391

1. PLACE OF DEATH
a. COUNTY: Elmore 700
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home AFB
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: 67 Tac Hosp, Mt Home AFB, ID 077

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 223 4th North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Baby Boy		NEWSOM	November	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cau	Never Married	13 Nov 69				2	56

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
02		Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Winfred Newsom	Weiser, Idaho	Rae Joan Porter	Portland, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		[signature]	Payette, Id 223 4th ST. N.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity- 34 weeks, primary Apnea — INTERVAL BETWEEN ONSET AND DEATH: 2hrs56Min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Erythroblastosis Fetalis, moderately severe
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 13 Nov *19* 69, *to* 13 Nov 69, *19*____, *that I last saw the deceased alive on* 13 Nov, *19* 69, *and that death occurred at* 1900 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 585	Mtn Home AFB, Idaho	13 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem-Bur. 3	Nov. 19, 1969	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 1 1969	[signature]	[signature]	E-388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
BIRTH NOV 24 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5228
Local Reg. No. 78
Reg. Dist. No. 380 391

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home - Rural
c. LENGTH OF STAY (In this place) at work
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 10 miles South of Mt. Home 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3120 Crescent Rim Drive

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) HARRY c. (Last) ANDERSON
4. DATE OF DEATH (Month) (Day) (Year) Nov. 18, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 2, 1907
9. AGE (In years last birthday) 62
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Foreman
10b. KIND OF BUSINESS OR INDUSTRY Idaho Power Co. 09
11. BIRTHPLACE (State or foreign country) Oregon
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BIRTHPLACE James Harvey Anderson, Halsey, Ore.
14. MOTHER'S MAIDEN NAME BIRTHPLACE Eudora Violott, Dallas Oregon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 540-09-0684
17. INFORMANT'S OWN SIGNATURE Thelma M. Anderson ADDRESS Boise, Idaho

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Investigation only, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Arthur Smith 533 Coroner
23b. ADDRESS Mountain Home, Idaho
23c. DATE SIGNED 11-19-60

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE 11-21-69
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. Nov 19 1969
REGISTRAR'S SIGNATURE
25. EMBALMER W. Verl Humphreys
LICENSE NO. E-502
FIRM NAME: SMITH MORTUARY, Mtn. Home, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 4 1969

FEB 2 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 1 1 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5229
Local Reg. No. 79
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 700
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn Home AFB
LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 67 TAC Hosp, Mt Home AFB, ID 077

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn Home AFB
d. STREET ADDRESS (If rural, give location): 4668 B Madison Pl

3. NAME OF DECEASED (Type or Print): a. (First) Julianna; b. (Middle); c. (Last) Sears

4. DATE OF DEATH: (Month) (Day) (Year) November 19 1969

5. SEX: Female

6. COLOR OR RACE: Filipino

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 7 Feb 35

9. AGE (In years last birthday): 34
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OD

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Cauite City, Phillipine Islands

12. CITIZEN OF WHAT COUNTRY?: P.I.

13. FATHER'S NAME: Martine Composuelo
BIRTHPLACE: Phillipine Islands

14. MOTHER'S MAIDEN NAME: Kerasig
BIRTHPLACE: Unknown Phillipine Islands

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Jackie E. Sears
ADDRESS: 4668 B Madison Mtn Home AFB, ID

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1808

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Disseminated Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma, uterine, cervix — 7 Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 Nov, 1969, *to* 19 Nov, 1969, *that I last saw the deceased alive on* 19 Nov, 1969, *and that death occurred at* 1725p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Julius Celano MD,

23b. ADDRESS: Mtn Home AFB, Idaho

23c. DATE SIGNED: 20 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/22/69

24c. NAME OF CEMETERY OR CREMATORY: Phillipine Islands

24d. LOCATION (City, town, or county) (State): Phillipine Islands

DATE REC'D BY LOCAL REG.: Nov 21 1969

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: H. Wel Humphreys
LICENSE NO.: E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 19 1971.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 18 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

NOV 24 1969

Bureau of Vital Statistics

State File No. 5230
Local Reg. No. 16
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 211
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 139 S 3rd E

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial Hospital 081

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) H. c. (Last) CHECKETTS

4. DATE OF DEATH: (Month) (Day) (Year) Oct 26, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 13, 1885

9. AGE (In years last birthday): 84
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: agriculture

11. BIRTHPLACE (State or foreign country): Providence, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George F. Checketts — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Mary J. Taylor — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-44-2126

17. INFORMANT'S OWN SIGNATURE: /s/ Linda W. Checketts — ADDRESS: Preston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerosis — 10 years

DUE TO (c): Chronic asthmatic bronchitis — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4369

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1945, *to* 10/26, 1969, *that I last saw the deceased alive on* 10/26, 1969, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leo R. Hampton M.D. 214

23b. ADDRESS: Preston, Idaho

23c. DATE SIGNED: 10/27/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: Oct 29, 1969

24c. NAME OF CEMETERY OR CREMATORY: Millville Cemetery

24d. LOCATION (City, town, or county) (State): Millville, Cache, Utah

DATE REC'D BY LOCAL REG.: 10-29-69

REGISTRAR'S SIGNATURE: Esper W. Brower

25. EMBALMER: Douglas S. Webb — LICENSE NO.: 488

FIRM NAME: WEBB FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

FEB 11 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5231
Local Reg. No. 17
Reg. Dist. No. 540

RECEIVED NOV 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
LENGTH OF STAY (in this place) 47 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial 08

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fairview
d. STREET ADDRESS (If rural, give location) RFD

3. NAME OF DECEASED (Type or Print) a. (First) ETHEL b. (Middle) MOORE c. (Last) TAYLOR BODILY

4. DATE OF DEATH (Month) (Day) (Year) Nov. 3, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 13, 1889
9. AGE (In years last birthday) 80
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Centerville, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter J. Moore
BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Margret Ann Frew
BIRTHPLACE Franklin, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 12 2468
17. INFORMANT'S OWN SIGNATURE X George L. Bodily
ADDRESS Fairview, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A — INTERVAL BETWEEN ONSET AND DEATH 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerotic Heart Disease — 3 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from Jan 1967, to Nov 3, 1969, that I last saw the deceased alive on Nov 3, 1969 and that death occurred at 1:34 P m., from the causes and on the date stated above.

23a. SIGNATURE O R Cutler (Degree or title) MD
23b. ADDRESS Preston Idaho
23c. DATE SIGNED 11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY Preston Cemetery
24d. LOCATION (City, town, or county) Preston, Idaho (State)

DATE REC'D BY LOCAL REG. 11-6-69
REGISTRAR'S SIGNATURE Effie W. Brower
25. EMBALMER Douglas S. Webb
LICENSE NO. 488

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 23 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 05 1998

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5232
Local Reg. No. 18
Reg. Dist. No. 340

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 21 NOV 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
LENGTH OF STAY (in this place) 16 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 237 East 1st South

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 21
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 237 East 1st South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	KIMBER	HANSEN	Nov. 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	March 12, 1915	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpentar 11	Painting & House building	Preston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lorenzo E. Hansen	Plain City, Utah	Maud Boswell	Grass Creek, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 4	518 07 9744	Mrs. Edward Coulton	Salt Lake City, Ut

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4927

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____ 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at about* 7A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Douglas S. Webb 583	Coroner	Preston Idaho	Nov 8 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 10, 1969	Preston Cemetery	Preston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-10-69	Effie W. Beaver	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Webb Funeral Home

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 5 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 24 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5233
Local Reg. No. 1
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
LENGTH OF STAY (in this place) 72 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Highway 89 ovv

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) North Highway 89

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EZRA	ARLEN	LARSON	November 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 18, 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (Retired)	Dairying	Preston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John A. Larson	Logan, Utah	Mira Allen	Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW I 3	519 03 6365	x Venetta Larson	Preston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Coronary Occlusion	Hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Coronary Heart disease	1 yr
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Prostate Malignancy	6 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-8, 1969, *to* 11-8, 1969, *that I last saw the deceased alive on* 11-8, 1969 *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. R. Cutler	122 MD	Preston Idaho	11-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 12, 1969	Preston Cemetery	Preston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-12-69	Esther W. Brauneck	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5234
Local Reg. No. 244
Reg. Dist. No. 650

RECEIVED NOV 19 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 22, Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) 25 North 12th West

3. NAME OF DECEASED (Type or Print) a. (First) CONRAD b. (Middle) "COONEY" H. c. (Last) BAUER

4. DATE OF DEATH (Month) (Day) (Year) Nov., 12, 1969

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 10, 1895

9. AGE (In years last birthday) 74
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pump Operator-City Water Dept, St. Anthony

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Hastings, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME C. C. Bauer
BIRTHPLACE Russia

14. MOTHER'S MAIDEN NAME Kathryn Herpst
BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW I 3

16. SOCIAL SECURITY NO. 544-26-4495

17. INFORMANT'S OWN SIGNATURE Roy Bauer ADDRESS St Anthony Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis — 15 yrs
DUE TO (c) A S H D — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1969, *to* 12 Nov, 1969, *that I last saw the deceased alive on* Nov 12, 1969, *and that death occurred at* 1:15 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 630 Lloyd Barrett MD
23b. ADDRESS St. Anthony, Idaho
23c. DATE SIGNED 15 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 15 Nov 69
24c. NAME OF CEMETERY OR CREMATORY Wilford Cemetery
24d. LOCATION (City, town, or county) (State) St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG. 17 Nov 69
REGISTRAR'S SIGNATURE M. D. Hansen
25. EMBALMER M. D. Hansen
LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 1 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5235
Local Reg. No. 44
Reg. Dist. No. 650

BIRTH NO.

RECEIVED
NOV 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 221
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): 307 No Bridge

3. NAME OF DECEASED (Type or Print)
a. (First): FREDRICK
b. (Middle): LEE
c. (Last): KELLAR

4. DATE OF DEATH: (Month) Nov., (Day) 19, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 13, 1900

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafe & Bar Operator 22

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Pike County, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Lee Kellar
BIRTHPLACE: Louisville, Kentucky

14. MOTHER'S MAIDEN NAME: Nancy Evelyn Lovelace
BIRTHPLACE: Pike Cty, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-20-0222

17. INFORMANT'S OWN SIGNATURE: Beulah K. Kellar
ADDRESS: St. Anthony, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD Pulmonary edem — 48 hrs
DUE TO (c) ASHD — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1962, *to* Nov, 1969, *that I last saw the deceased alive on* Nov 19, 1969 *and that death occurred at* 8:30 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lloyd Barth MD

23b. ADDRESS: St. Anthony, Idaho

23c. DATE SIGNED: 21 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 22 Nov 69

24c. NAME OF CEMETERY OR CREMATORY: Little Butte Cemetery

24d. LOCATION (City, town, or county) (State): Annis, Jefferson, Idaho

DATE REC'D BY LOCAL REG.: 22 Nov 69

REGISTRAR'S SIGNATURE: M. D. Hansen

25. EMBALMER: M. D. Hansen

LICENSE NO.: E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 28 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5236
Local Reg. No. 28
Reg. Dist. No. 651

RECEIVED
NOV 28 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony-Rural
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) RFD#1- Wilford

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony-Rural
d. STREET ADDRESS (If rural, give location) RFD#1- Wilford

3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH b. (Middle) RICHARDS c. (Last) DAYTON

4. DATE OF DEATH (Month) (Day) (Year) Nov., 22, 1969

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Oct., 22, 1872
9. AGE (In years last birthday) 97
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY 01
11. BIRTHPLACE (State or foreign country) North Ogden, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Richards-Neath Abby, Glamorgan, Wales
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Adelaide Rose
BIRTHPLACE Council Bluffs, Ia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-62-1385
17. INFORMANT'S OWN SIGNATURE Mark B. Dayton
ADDRESS St. Anthony, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio sclerotic cardio-vascular disease — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Extreme age - Pyelonephritis, chr.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1961, *to* Nov, 1969, *that I last saw the deceased alive on* Nov 9, 1969, *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Rexburg, Idaho
23c. DATE SIGNED 26 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 26 Nov 69
24c. NAME OF CEMETERY OR CREMATORY Wilford Cemetery
24d. LOCATION (City, town, or county) (State) St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG. 26 Nov 69
REGISTRAR'S SIGNATURE M. L. Hansen
25. EMBALMER M. L. Hansen
LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5237
Local Reg. No. 47
Reg. Dist. No. 650

RECEIVED DEC 8 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 221
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Anthony
c. LENGTH OF STAY (If not in place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Anthony
d. STREET ADDRESS (If rural, give location): 224 E. 4 N. Street

3. NAME OF DECEASED (Type or Print)
a. (First): INEZ
b. (Middle): CAMPBELL
c. (Last): MILLER

4. DATE OF DEATH (Month) (Day) (Year): November 26, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: August 2, 1904
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Victor, Idaho
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John B. Campbell — BIRTHPLACE: Spanish Fork, Utah
14. MOTHER'S MAIDEN NAME: Tlitha Humble — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-03-9812B
17. INFORMANT'S OWN SIGNATURE: Garn A. Miller — ADDRESS: 444 N. 1150 E. Bountiful, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerosis — 7 yrs.
DUE TO (c) Chronic Myocarditis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1953, *to* Nov 26, 1969, *that I last saw the deceased alive on* Nov. 26, 1969, *and that death occurred at* 8:30 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. F. Rigby MD 442
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: Nov. 29 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Nov. 29, 1969
24c. NAME OF CEMETERY OR CREMATORY: Victor Cemetery
24d. LOCATION (City, town, or county) (State): Victor Teton Idaho

DATE REC'D BY LOCAL REG.: 29 Nov 69
REGISTRAR'S SIGNATURE: M. L. Hansen
25. EMBALMER: Kenneth Flamm
LICENSE NO.: E347

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flamm Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5288
Local Reg. No. 28
Reg. Dist. No. 657

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Fremont — DEC 8 1969
b. CITY OR TOWN: Ashton
c. LENGTH OF STAY: 2 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): 809 Pine St.

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print): a. (First) Nolen; b. (Middle) N.; c. (Last) Whittemore

4. DATE OF DEATH: (Month) (Day) (Year) November 29, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 28, 1909

9. AGE (In years last birthday): 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk/Bookkeeper 09

10b. KIND OF BUSINESS OR INDUSTRY: Electric Power Co.

11. BIRTHPLACE (State or foreign country): Detroit Lakes, Minn.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Drew S. Whittemore
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Minnie Boss
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.: 521-16-5228

17. INFORMANT'S OWN SIGNATURE: x Mrs Nolen Whittemore
ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic coronary heart disease
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 4 hours / 17 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-20 1969 *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 8 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 298

23b. ADDRESS: ASHTON IDAHO

23c. DATE SIGNED: 12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec 2, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery

24d. LOCATION (City, town, or county) (State): Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: 5 Dec 69

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature]

LICENSE NO.: E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 13 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 21 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5239
Local Reg. No. 32
Reg. Dist. No. 340.34

BIRTH NO.

RECEIVED
DEC 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 231 Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 2 days
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Walter Knox Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) SARAH b. (Middle) A. c. (Last) HEATH

4. DATE OF DEATH (Month) (Day) (Year) October 26, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Feb. 1, 1880

9. AGE (In years last birthday) 89
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Atchenson, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jesse M. Croft
BIRTHPLACE Kansas

14. MOTHER'S MAIDEN NAME Anna Richards
BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-58-9623

17. INFORMANT'S OWN SIGNATURE Mrs Jake Ritter
ADDRESS Caldwell, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-4 1954, to 10-26- 1969, that I last saw the deceased alive on 10-26-69, 19____, and that death occurred at 7:38p m., from the causes and on the date stated above.

23a. SIGNATURE Harmon E. Halverson (241) (Degree or title) MD

23b. ADDRESS Emmett, Idaho

23c. DATE SIGNED 12-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 31, 1969

24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery

24d. LOCATION (City, town, or county) Emmettt (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 10, 1969

REGISTRAR'S SIGNATURE Jean A Beatty

25. EMBALMER Glen L. Sires

LICENSE NO. E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

NOV 17 1969

Bureau of Vital Statistics

State File No. 5240
Local Reg. No. 24
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 231 Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 1 1/2 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) Sharrai Court

3. NAME OF DECEASED (Type or Print) a. (First) Jack b. (Middle) c. (Last) Gofourth

4. DATE OF DEATH (Month) (Day) (Year) November 3, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Nov. 5, 1915
9. AGE (In years last birthday) 53
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 04
10b. KIND OF BUSINESS OR INDUSTRY farm
11. BIRTHPLACE (State or foreign country) Madison Co. North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lydge Gofourth BIRTHPLACE North Carolina
14. MOTHER'S MAIDEN NAME Lourry Norris BIRTHPLACE North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 530-42 1567
17. INFORMANT'S OWN SIGNATURE X Eunice Dean ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Lung lacerations — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Head injury & cerebral edema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Letha Idaho 06
21c. (CITY, TOWN, OR TOWNSHIP) Letha Ida 13230 (COUNTY) Gem (STATE) Idaho

21d. TIME OF INJURY (Month) 11 (Day) 3 (Year) 69 (Hour) 4:00 p.m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Car accident - thrown from car

22. I hereby certify that I attended the deceased from Nov 3, 1969, to Nov 3, 1969, that I last saw the deceased alive on Nov 3, 1969, and that death occurred at 5:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE Wm B. Jewell MD. 260 (Degree or title)
23b. ADDRESS 1024 E. Locust, Emmett, Ida
23c. DATE SIGNED 11-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) removal
24b. DATE Nov. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY Sterling
24d. LOCATION (City, town, or county) Sterling, Illinois (State)

DATE REC'D BY LOCAL REG. Nov. 13, 1969
REGISTRAR'S SIGNATURE Jean A Beatty
25. EMBALMER Glenn W Beatty
LICENSE NO. E392
FIRM NAME The Beatty Chapel

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5241
Local Reg. No. 28
Reg. Dist. No. 340 341

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: 120 So. Boise

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 120 So. Boise

3. NAME OF DECEASED (Type or Print): a. (First) John; b. (Middle) Wesley; c. (Last) Acton

4. DATE OF DEATH (Month) (Day) (Year): Nov. 6, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: June 15, 1908

9. AGE (In years last birthday): 61
IF UNDER 1 YR. Months: 4 Days: 21
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): plumber

10b. KIND OF BUSINESS OR INDUSTRY: construction

11. BIRTHPLACE (State or foreign country): Fruita, Oregon

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: unknown
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: unknown
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 712-07-6574

17. INFORMANT'S OWN SIGNATURE: Police records or Public Asst. Records
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* never *, 19____, to [illegible], 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at* unknown *from the causes and on the date stated above.*

23a. SIGNATURE: Glenn W Beatty 583 4 (Degree or title): Coroner Gem County

23b. ADDRESS: Emmett, Idaho

23c. DATE SIGNED: 11-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Nov. 13, 1969

24c. NAME OF CEMETERY OR CREMATORY: Sweet

24d. LOCATION (City, town, or county) (State): Sweet, Idaho

DATE REC'D BY LOCAL REG.: Nov. 13, 1969

REGISTRAR'S SIGNATURE: Glenn W Beatty

25. EMBALMER: Glenn W Beatty

LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5242
Local Reg. No. 25
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 231 Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 2hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 317 West 4th St

3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) Edmond c. (Last) Prew
4. DATE OF DEATH (Month) (Day) (Year) Nov. 6, 1969
5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced
8. DATE OF BIRTH Jan. 16, 1898
9. AGE (In years last birthday) 71 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter
10b. KIND OF BUSINESS OR INDUSTRY building
11. BIRTHPLACE (State or foreign country) Montague, Mass.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph A. Prew
BIRTHPLACE Cariboe, Maine
14. MOTHER'S MAIDEN NAME Ruth Esther
BIRTHPLACE Monroe Mass.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 328 07 6483
17. INFORMANT'S OWN SIGNATURE Glenn W Beatty ADDRESS Emmett Ida
Birth Cert.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4270

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH 4 DAYS

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) UNABLE TO GET ANY FURTHER HISTORY PT DIED ONE HOUR
DUE TO (c) AFTER ADMITTANCE,

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from NOV 6 1969, to NOV 6 (ONE HOUR) 1969, that I last saw the deceased alive on NOV 6, 1969, and that death occurred at 2 p.m., from the causes and on the date stated above.

23a. SIGNATURE Lowell P. Lawhorn MD (Degree or title)
23b. ADDRESS 108 W 2nd St EMMETT, IDA
23c. DATE SIGNED NOV 10 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE Nov. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY Sterling
24d. LOCATION (City, town, or county) (State) Sterling. Ill.

DATE REC'D BY LOCAL REG. Nov. 11, 1969
REGISTRAR'S SIGNATURE Jean A Beatty
25. EMBALMER Glenn W Beatty
LICENSE NO. E392
FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 18 1969 Bureau of Vital Statistics

State File No. 5243
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 23

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett

LENGTH OF STAY (In this place) 1 1/2 yrs

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shady Lane Nursing Home 265

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Madonna b. (Middle) J. c. (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	divorced	June 29, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
clerk 25	store	Leon, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Maholn Shira	unknown	Stanford	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519 10 7739 A	Public Asst. Records Glenn W Beatty	Emmett

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

3247

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Post Encephalitis Athetosis — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-30 19 68 *to* 11-7 19 69 *, that I last saw the deceased alive on* 10-21-69 *, 19____, and that death occurred at* 4:40 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harmon E. Halvorson MD	Emmett, Idaho	11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3	Nov. 11, 1969	Mtn. View	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 18, 1969	Jean A. Beatty	Glenn W Beatty	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

JUN 2 9 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5244
Local Reg. No. 37
Reg. Dist. No. 340 [illegible]

BIRTH NO.

NOV 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Gem 231	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett; c. LENGTH OF STAY (In this place) 3 wks.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Emmett Valley Manor 302	d. STREET ADDRESS (If rural, give location) 500 West 4th

3. NAME OF DECEASED (Type or Print)	a. (First) Luisa	b. (Middle) Bermasola	c. (Last) Eiguren	4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1969
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan. 21, 1898	9. AGE (In years last birthday) 71; IF UNDER 1 YR. Months 9 Days 20; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Lequetio, Viscaya, Spain	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pedro Bermasola	BIRTHPLACE Spain	14. MOTHER'S MAIDEN NAME Modesta Acarregui	BIRTHPLACE Spain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-07-3489	17. INFORMANT'S OWN SIGNATURE X Louis Eiguren	ADDRESS	

18. CAUSE OF DEATH 4100
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Occlusion	Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertensive Cardiovascular Disease	Years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-15, 1957, *to* 11-11, 1969, *that I last saw the deceased alive on* 10-31-69, 19___, *and that death occurred at* 5:55P *m., from the causes and on the date stated above.*

23a. SIGNATURE Harmon E. Holmes MD (Degree or title)	23b. ADDRESS Emmett, Idaho	23c. DATE SIGNED 11-12-69
24a. BURIAL, CREMATION, REMOVAL (Specify) burial; 24b. DATE Nov. 15, 1969	24c. NAME OF CEMETERY OR CREMATORY Emmett	24d. LOCATION (City, town, or county) (State) Emmett, Idaho
DATE REC'D BY LOCAL REG. Nov. 16, 1969; REGISTRAR'S SIGNATURE Jean A. Beatty	25. EMBALMER Glenn W Beatty	LICENSE NO. E-392

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME THE BEATTY CHAPEL Emmett, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 8 1969 Bureau of Vital Statistics

State File No. 5245
Local Reg. No. 29
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): 3days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Route 1 Box 342

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 085

3. NAME OF DECEASED (Type or Print): a. (First) Daniel b. (Middle) Ross c. (Last) Rivers

4. DATE OF DEATH: November 19, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: January 15, 1909

9. AGE (In years last birthday): 60 | IF UNDER 1 YR. Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): lumber piler 17

10b. KIND OF BUSINESS OR INDUSTRY: lumber

11. BIRTHPLACE (State or foreign country): Oakley, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William A. Rivers
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Mary Ann McLaws
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: $19 30 6056

17. INFORMANT'S OWN SIGNATURE: Marion L. Rivers
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of lung
INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-16- , 19 62 , *to* 11-19 , 19 69 , *that I last saw the deceased alive on* 11-19- , 19 69 , *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Harmon E. Halverson (Degree or title) MD

23b. ADDRESS: Emmett, Idaho 83617

23c. DATE SIGNED: 11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Nov. 21, 1969

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: 12-4-69

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Jean W Beatty

LICENSE NO.: E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5246
Local Reg. No. 30
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shady Lane Nursing Home 265

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 706 So. Hayes

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) E. c. (Last) Riggs

4. DATE OF DEATH (Month) (Day) (Year) November 28, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH November 20, 1872

9. AGE (In years last birthday) 97

IF UNDER 1 YR. Months 0 Days 8

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher 12

10b. KIND OF BUSINESS OR INDUSTRY education

11. BIRTHPLACE (State or foreign country) Clinton, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Wilkins
BIRTHPLACE Mass.

14. MOTHER'S MAIDEN NAME Mary Frances Putnam
BIRTHPLACE Mass.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-56-7138

17. INFORMANT'S OWN SIGNATURE Mary R Eacker
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 15, 1969 to Nov. 28, 1969, that I last saw the deceased alive on Nov 28, 1969, and that death occurred at 1:05 p m., from the causes and on the date stated above.

23a. SIGNATURE Wm B Jewell M.D. 260 (Degree or title)

23b. ADDRESS 1024 E. Locust, Emmett, Idaho

23c. DATE SIGNED 12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Dec. 1, 1969

24c. NAME OF CEMETERY OR CREMATORY Emmett Cemetery

24d. LOCATION (City, town, or county) Emmett, Idaho (State)

DATE REC'D BY LOCAL REG. 12.5.69

REGISTRAR'S SIGNATURE Jean A Beatty

25. EMBALMER Walter Potter

LICENSE NO. E 445

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

State File No. 5247
Local Reg. No. 3180
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural--Gooding
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 Miles So. & 1-3/4 West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 345 Wyoming St.

3. NAME OF DECEASED (Type or Print)
a. (First) Mack
b. (Middle) Henry
c. (Last) Shotwell

4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Dec. 3, 1890
9. AGE (In years last birthday) 78
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Post Master 08
10b. KIND OF BUSINESS OR INDUSTRY Postal Dept.
11. BIRTHPLACE (State or foreign country) Grand Junction, Colo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jasper S. Shotwell
BIRTHPLACE Clinton, Mo.
14. MOTHER'S MAIDEN NAME Amy Colclasure
BIRTHPLACE Noxvill, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes.
(If yes, give war or dates of service) W.W. #1 3
16. SOCIAL SECURITY NO. 518-48-7687-0
17. INFORMANT'S OWN SIGNATURE Mary E. Olander
ADDRESS Rt #2 Gooding, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH Minutes.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* November 11, 19 69, *that I last saw the deceased alive on* Nov. 11, 1969, 19__, *and that death occurred at* 12:30 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE Marion A. Kingston 285 (Degree or title)
23b. ADDRESS Gooding, Idaho
23c. DATE SIGNED 11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-15-1969
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) Gooding, (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 17, 1969
REGISTRAR'S SIGNATURE Eddie G. Leach
25. EMBALMER Eddie G. Leach
LICENSE NO. C-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 0 1969
DEC 1 8 1969
JUN 4 1970
SEP 1 2 1984
APR 1 4 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5248
Local Reg. No. 3181
Reg. Dist. No. 420

BIRTH NO.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hospital 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman
d. STREET ADDRESS (If rural, give location): P.O. Box 364

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Sadie	Elizabeth	Ruddles	November 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Oct. 29, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Webb City, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hiram Campbell	Unknown	Charity McMasters	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-----	518-16-5607-A	Mrs. Stanley Kirtland	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5609

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Previous operation for obstruction
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov. 18, 1969, *to* Nov. 21, 1969, *that I last saw the deceased alive on* 11-21-69, 19____, *and that death occurred at* 7:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvin D. Vaughn 285	Gooding, Idaho	11-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-[illegible]-1969	Hagerman Cemetery	Hagerman Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 25 1969	Eddie G. Leach	Eddie G. Leach	C-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Idaho

SEP 1 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5249
Local Reg. No. 3182
Reg. Dist. No. 420

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240 — DEC 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural--Bliss
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7 Miles west of Bliss ooo

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield
d. STREET ADDRESS (If rural, give location): P.O. Box 331

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Beatrice	Irene	Durall	November 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Oct. 23, 1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	Domestic	Pullman, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Chandler	Tenn.	Rhoda Ewert	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no -------	518-54-4010	X Harry Durall	Fairfield, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov. 25 1969, 19___, *to* Nov 27 1969, 19___, *that I last saw the deceased alive on* Nov. 27, 1969, 19___, *and that death occurred at* 3:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvel C. Thompson 285	Gooding, Idaho	11-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-1-1969	Cloverdale Mem. Park	Boise Ada Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	EMBALMER	LICENSE NO.
December 2, 1969	Eddie C. Leach	Eddie C. Leach	C-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Idaho

DEC 5 1969

AUG 2 7 1976

JUN 1 0 2011

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5250
Local Reg. No. 69
Reg. Dist. No. 240

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
NOV 14 1969

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho County Nursinghome 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Rural Rt # 2 (Foothills)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	S	WARDEN	Nov 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Oct 20, 1878	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 08	U.S. Forest Service	Ottumwa, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur Warden	Unknown	Alura Montague	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519 05 2868A	Jack Warden	Grangeville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: Several months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Lower urin. tract
DUE TO (c) obstruction - prostate hypertrophy several years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gen. arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4-29-, 19 69 *to* 2 Nov, 19 69, *that I last saw the deceased alive on* 1 Nov, 19 69, *and that death occurred at* 5:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donal Voltmer M.D.	Grangeville Idaho	5 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 5 1969	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 8, 1969	Irma Cone	Robert R Hansen	E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5251
Local Reg. No. 70
Reg. Dist. No. 240

BIRTH NO.

RECEIVED NOV 14 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 250 Idaho
b. CITY OR TOWN Grangeville
c. LENGTH OF STAY (If hospital) 9 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho County Nursing Home 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) 1015 Middle Street

3. NAME OF DECEASED (Type or Print) a. (First) HOWARD b. (Middle) W c. (Last) HOLMES

4. DATE OF DEATH (Month) (Day) (Year) Nov 5, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Sept 7, 1887

9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 17

10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill

11. BIRTHPLACE (State or foreign country) Accree, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Holmes — BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Elizabeth Corley — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW I 3

16. SOCIAL SECURITY NO. 510 16 4713

17. INFORMANT'S OWN SIGNATURE X Ronald P. Aiken — ADDRESS Grangeville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left lower lobe pneumonia — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Bronchiectasis — 10 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov., 1969, *to* Nov, 1969, *that I last saw the deceased alive on* Nov. 2, 1969, *and that death occurred at* 5:10A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD — **23b. ADDRESS** Grangeville Ida — **23c. DATE SIGNED** 11/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** Nov 8, 1969 — **24c. NAME OF CEMETERY OR CREMATORY** Prairieview — **24d. LOCATION** (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Nov. 10 1969 — **REGISTRAR'S SIGNATURE** Irma Cone

25. EMBALMER Robert R Hansen — **LICENSE NO.** E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5252
Local Reg. No. 29
Reg. Dist. No. 242

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho DEC 1 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cottonwood
c. LENGTH OF STAY (In this place) 15 M S
d. FULL NAME OF HOSPITAL OR INSTITUTION rural near Graves Creek

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Lewis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Craigmont
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ellis	G.	Thor	Nov	21	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	Apr 18 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (retired) 04	stock & grain	Sweden	U S

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mangus Thor		unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	W W I 3	519 42 2825	Darlene K. Dorion	Lewiston Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7824

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Apparent Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Cottonwood 15 Miles South Idaho Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Nov.	21	69	1:30P		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____ *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 4	IDAHO COUNTY CORONER	11 29 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov 24 1969	L O O F	Craigmont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Elizabeth H. Uhlorn	Clelus F. Uhlorn	E 421

FIRM NAME: UH LORN FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969
JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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Certificate of Death

STATE OF IDAHO

State File No. 5253
Local Reg. No. 123
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 — DEC 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville — c. LENGTH OF STAY in this place: 30 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Hill Manor 381

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia
d. STREET ADDRESS (If rural, give location): at Syringa

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Melvin	Oliver	Robinett	Nov. 23 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	Never married	August 5, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.S.F.S. employee 08	Forestry	Kamiah, Idaho.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oliver P. Robinett	Harrisburg Ore.	Matilda Ann	Moscow, Idaho.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-22-6507	June Ky nearson	Kooskia, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Myeloma 203 X — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. widespread bone metastasis and pathological fractures

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1967, *to* Nov 23, 1969, *that I last saw the deceased alive on* Nov 23, 1969, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm Thomson MD 373	Grangeville Id	11/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY ~~OR CREMATORY~~	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 25 1969	Pine Grove	Kooskia Idaho, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 1, 1969	Irma Cone	Robert Hansen	E453

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5254
Local Reg. No. 76
Reg. Dist. No. 240

Certificate of Death

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville Gen. Hosp 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
d. STREET ADDRESS (If rural, give location): Kamiah, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): JACK
b. (Middle):
c. (Last): WILLIAMS

4. DATE OF DEATH (Month) (Day) (Year): November 26, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Feb 22, 1907
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: various
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Robert Hansen County Records R.H. — ADDRESS: Grangeville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5150

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: few days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Silicosis — sev. years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 24 Nov., 1969, *to* 26 Nov, 1969, *that I last saw the deceased alive on* 26 Nov, 1969, *and that death occurred at* 6:10 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald Seltman M.D. 487
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 11 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): 3 Burial
24b. DATE: 12/2/1969
24c. NAME OF CEMETERY OR CREMATORY: Kamiah
24d. LOCATION (City, town, or county) (State): Kamiah, Idaho

DATE REC'D BY LOCAL REG.: Dec. 15 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433
FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5255
Local Reg. No. 73
Reg. Dist. No. 140

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 252 Idaho
b. CITY OR TOWN Grangeville | STAY (in this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION 092 Grangeville General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Idaho 250
c. CITY OR TOWN Fenn, Idaho
d. STREET ADDRESS (If rural, give location) Fenn, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ADDIE		VON BERGE	November 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	MAY 27, 1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife & Farming	Own Home	Fenn, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John H Von Berge	Germany	Sophia Rathe	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 60 5565 J-1	Mrs Richard Hauger	Fenn, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Septic Shock — INTERVAL BETWEEN ONSET AND DEATH: 16 Hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) acute Peritonitis — unkn
DUE TO (c) Small Bowel Obstruction — Approx 5 Days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Dementia of Unknown Cause; Nephrosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 28 1969 *to* Nov 29 1969, *that I last saw the deceased alive on* Nov 29, 1969, *and that death occurred at* 7A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm Mannin MD 373		12/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 2, 1969	Denver, Cemetery	Grangeville, Idaho Rural

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 9, 1969	Irma Cone	Robert P Hansen / Robert P Hansen	1433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5256
Local Reg. No. 12
Reg. Dist. No. 640

RECEIVED DEC 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clark
c. LENGTH OF STAY (in this place): 8 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carson Nursing Home 097

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ririe (rural)
d. STREET ADDRESS (If rural, give location): Rte. #2 Rigby

3. NAME OF DECEASED (Type or Print): a. (First) MARGARET b. (Middle) IDA c. (Last) JOHNSON

4. DATE OF DEATH: October 31, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 3, 1898

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Omaha, Nebraska.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Antoine Marquet — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Ida Louise Vandering — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-60-6097

17. INFORMANT'S OWN SIGNATURE: Earl Johnson — ADDRESS: Rigby, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 hours.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic Heart Disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Duodenal ulcer — years.

4123

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: None performed

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 3, 1960, *to* 31 Oct., 1969, *that I last saw the deceased alive on* 31 Oct., 1969, *and that death occurred at* 6:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Tall, 522 — (Degree or title): M.D.

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: 3 Nov. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: Nov. 3, 1969

24c. NAME OF CEMETERY OR CREMATORY: Ririe-Shelton

24d. LOCATION (City, town, or county) (State): Shelton, Bonneville, Idaho.

DATE REC'D BY LOCAL REG.: Nov. 3 1969

REGISTRAR'S SIGNATURE: Mrs A B Eckersell

25. EMBALMER: Bruce A. Eckersell — Bruce A. Eckersell

LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5257
Local Reg. No. 1269
Reg. Dist. No. 440

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hsoptial 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Wendell 83355
d. STREET ADDRESS (If rural, give location): 3½ miles East and ½ mile So. of City

3. NAME OF DECEASED (Type or Print)
a. (First): LUCIA
b. (Middle): ANNA
c. (Last): ASMUSSEN

4. DATE OF DEATH (Month) (Day) (Year): Nov. 10, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 21, 1892
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Payette, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: C. F. Asmussen — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Sophia Nammany — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-42-6448
17. INFORMANT'S OWN SIGNATURE: Robert E. Asmussen — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4122

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral vascular accident	4 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hyper-cardio vascular disease	15 yrs.
DUE TO (c)	Cerebral arteriosclerosis	10 yrs.
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/18/, 1947, *to* 11/10, 1969, *that I last saw the deceased alive on* 11-10, 1969, *and that death occurred at* 8:25 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold G. Halsinger MD 240
23b. ADDRESS: Wendell, Ida
23c. DATE SIGNED: 11-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Nov. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Wendell Cemetery
24d. LOCATION (City, town, or county) (State): Wendell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17, 1969
REGISTRAR'S SIGNATURE: Lorella M. Osborn
25. EMBALMER: Joe B. Leeper Joe B. Leeper
LICENSE NO.: E-530

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Leeper Mortuary Wendell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 2 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5258
Local Reg. No. 1268
Reg. Dist. No. 440

BIRTH NO.

RECEIVED
NOV 13 1969
Bureau of Vital St.

1. PLACE OF DEATH a. COUNTY Jerome 270	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) 83338
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 mi south and 2½ mi east of Jerome 000	d. STREET ADDRESS (If rural, give location) Rt. # 4

3. NAME OF DECEASED (Type or Print)	a. (First) JUANITA	b. (Middle) FERN	c. (Last) McLEAN	4. DATE OF DEATH (Month) (Day) (Year) Nov. 10, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 15, 1934	9. AGE (In years last birthday) 35 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Relief Mail Carrier 08	10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	11. BIRTHPLACE (State or foreign country) Wendell, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theon Zahn	BIRTHPLACE no record	14. MOTHER'S MAIDEN NAME Dorothy Meeks	BIRTHPLACE Arkansas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518 36 5572	17. INFORMANT'S OWN SIGNATURE X Orwell McLean	ADDRESS Rt. 4, Jerome, Idaho	

8199

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Auto Accident — INTERVAL BETWEEN ONSET AND DEATH: NONE

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fire

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT [redacted] (Specify) Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) County Road 06.	21c. (CITY, TOWN, OR TOWNSHIP) 13270	(COUNTY) Jerome, (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 10 69 10:50 AM	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? Auto Accident	

22. *I hereby certify that I attended the deceased from* ——, 19__, *to* ——, 19__, *that I last saw the deceased alive on* ——, 19__, *and that death occurred at* 10:50 A.m., *from the causes and on the date stated above.*

JUSTICE OF THE PEACE

23a. SIGNATURE Irving Altman 583	23b. ADDRESS Jerome, Idaho	23c. DATE SIGNED Nov. 12, 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 13, 1969	24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery	24d. LOCATION (City, town, or county) (State) Jerome, Idaho
DATE REC'D BY LOCAL REG. Nov. 12 1969	REGISTRAR'S SIGNATURE Louella M. Deherer	25. EMBALMER W. L. Hove	LICENSE NO. E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5259
Local Reg. No. 1270
Reg. Dist. No. 440

BIRTH NO.

RECEIVED
NOV 19 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Nursing Home 357

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 1020 North Buchanan

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEWIS	CLYDE	BEVENS	Nov. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 30, 1882	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (ret) 04	Agriculture	Hubbard, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Amos Bevens	no record	Emmie Beard	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 40 7157	* Mrs Pearl M. Bevens	Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebralvascular accident, thrombotic — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis, generalized — years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Auricular fibrilation — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from August 5, 1969, to November 14, 1969, that I last saw the deceased alive on November 6, 1969, and that death occurred at 8:50A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jon D. Wilmoth, M.D. 770	214 East Main, Jerome, Idaho	Nov. 17, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 18, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 18 1969	Louella M. Deherer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

NOV 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5260
Local Reg. No. 1272
Reg. Dist. No. 440

BIRTH NO.

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 229 East Ave A

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) J. c. (Last) Meiser

4. DATE OF DEATH: November 15 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 11/ 23 / 98

9. AGE (In years last birthday): 70 | IF UNDER 1 YR. Months: 11 Days: 22 | IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): McPherson Kansas

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Rasmussen Mogensen
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Margaret Anderson
BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-42-5799

17. INFORMANT'S OWN SIGNATURE: X W. W. Meiser
ADDRESS: Jerome Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4122

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Rupture aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 15 mm

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arthritis both knees — 15 yrs
DUE TO (c): Hypertensive Cardio-~~Pulmonario~~-vascular disease — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Diaphragmatic hernia (rpaired) — 1 yr.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12/31/ , 19 59 *to* 11/15/69 , 19 , *that I last saw the deceased alive on* 11/3/ , 19 69, *and that death occurred at* 8:10 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): Harold G. Holsinger M.D. 240

23b. ADDRESS: Wendell, Idaho

23c. DATE SIGNED: 11/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: 11/18/1969

24c. NAME OF CEMETERY OR CREMATORY: Filer Cemetery

24d. LOCATION (City, town, or county) (State): Filer Idaho

DATE REC'D BY LOCAL REG.: Nov. 19, 1969

REGISTRAR'S SIGNATURE: Louella M. Scherer

25. EMBALMER: J R Wiley

LICENSE NO.: E-258

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5261
Local Reg. No. 1271
Reg. Dist. No. 440

BIRTH NO.

RECEIVED NOV 19 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St. Benedict's Hosp. 094

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 221 3rd. Ave. East

3. NAME OF DECEASED (Type or Print): a. (First) HEBER b. (Middle) L. c. (Last) PRESCOTT

4. DATE OF DEATH (Month) (Day) (Year): Nov. 16, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 23, 1909

9. AGE (In years last birthday): 60
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sundry jobber 06

10b. KIND OF BUSINESS OR INDUSTRY: Wholesale

11. BIRTHPLACE (State or foreign country): Cleveland, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Byrum Prescott
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Maria Smith
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 18 2173

17. INFORMANT'S OWN SIGNATURE: X Mrs. Gerald Prescott
ADDRESS: Portland, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Angina Pectoris — 2-3 yrs.
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dead upon arrival — *to* —, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 12:40P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Reuben C. Matson MD

23b. ADDRESS: Jerome Ida

23c. DATE SIGNED: 11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery

24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: Nov. 18, 1969

REGISTRAR'S SIGNATURE: Lenora M. Dekerer

25. EMBALMER: W. L. Hove

LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Hove Funeral Chapel

DEC 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5262
Local Reg. No. 1273
Reg. Dist. No. 440

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
c. LENGTH OF STAY (In this place) 16 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedicts Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Wendell 83355
d. STREET ADDRESS (If rural, give location) 5½ So. and 4 West of Wendell

3. NAME OF DECEASED (Type or Print)
a. (First) Elmer
b. (Middle) Richard
c. (Last) THOMPSON

4. DATE OF DEATH (Month) Nov. (Day) 18, (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 25, 1925
9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Buhl, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herbert Thompson — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Emma Breaite — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-22-3922
17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Wendell

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2022

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) malignant lymphoma

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) metastated - widespread

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9- 12, 19 58, *to* 11-18, 19 69, *that I last saw the deceased alive on* 11-18, 19 69, *and that death occurred at* 12:35 m. *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 68 +57
23b. ADDRESS Wendell, Idaho 83355
23c. DATE SIGNED 11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Nov. 21, 1969
24c. NAME OF CEMETERY OR CREMATORY: Gem Memorial Gardens
24d. LOCATION (City, town, or county) (State): Burley Idaho

DATE REC'D BY LOCAL REG.: Nov. 24 1969
REGISTRAR'S SIGNATURE: Louella M. Pahrer
25. EMBALMER: Joe B. Leeper [signature] LICENSE NO. E-530

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Leeper Mortuary Wendell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 18 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 5263
Local Reg. No. 1274
Reg. Dist. No. 440

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH — a. COUNTY: Jerome — DEC 1 1969 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome — c. LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — a. STATE: Idaho — b. COUNTY: Jerome — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338 — d. STREET ADDRESS (If rural, give location): 300 1st. Ave. West Apt. 5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	Melvin	Olson	Nov. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never married	April 23, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer (farm)	Agriculture	Elsmore, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Axel Olson	no record	Martha Jensen	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 30 1579A	Nelda S. Clark	Burley, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Cardiac tamponad — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary Thrombosis & Infarction — 2 mos

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11/21, 1969 *to* 11/21, 1969 *that I last saw the deceased alive on* 11/21, 1969 *and that death occurred at* 11:59A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. Moat 476	MD.	Jerome Idaho	11/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 24, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 26, 1969	Louella M. Deherer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

DEC 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5264
Local Reg. No. 1275
Reg. Dist. No. 440

BIRTH NO.

RECEIVED Bureau of Vital Statistics DEC 1 1969

1. PLACE OF DEATH a. COUNTY: Jerome 270	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome c. LENGTH OF STAY (in this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099	d. STREET ADDRESS (If rural, give location): 300 4th Ave. West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOSEPH	WILLIAM	ROBINSON	Nov. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Mar. 6, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (ret) 04	Agriculture	Liberty, UTAH	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard W. Robinson	no record	Elizabeth L. Gardner	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519-05-5478	X Ella Robinson	Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Fractures of skull, both orbits, ribs, pelvis, rt hip, compound rt tibia & fibula — INTERVAL BETWEEN ONSET AND DEATH: 17 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic pneumonia, terminal — 3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11/12/69	Reduction rt tibia & fibula (No anesthetic)	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) 04	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Struck by auto	3270	Jerome, Jerome, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Nov. 11, 1969 8:30 p.m.		Pedestrian struck by auto

22. *I hereby certify that I attended the deceased from* 11/11/69, 19__, *to* 11/23/69, 19__, *that I last saw the deceased alive on* 11/23/69, 19__, *and that death occurred at* 6:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
N. Carlyle Burial	M.D.	Jerome, Idaho	11/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 26, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 26, 1969	Louella M. Schurer	W. L. Hove	E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 1969
JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED DEC 3 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5265
Local Reg. No. 1276
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eden 83325
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Trophy Lounge 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eden 83325
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) O. c. (Last) LAWHORN

4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan. 30, 1906
9. AGE (In years last birthday) 63
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Mountain Home, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wm. Jacob Lawhorn BIRTHPLACE Ava, Missouri
14. MOTHER'S MAIDEN NAME Belle Dora Chandler, Mt. Home, Arkansas BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-22-7382
17. INFORMANT'S OWN SIGNATURE Mary O. Lawhorn ADDRESS Eden, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH few minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——— , 19____ , to ——— , 19____ , *that I last saw the deceased alive on* ——— , 19____ , *and that death occurred at* 3:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE R. W. Fisher, Co. Cor. 583 (Degree or title) Coroner
23b. ADDRESS Jerome
23c. DATE SIGNED 12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE Nov. 28, 1969
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. Dec. 1 1969
REGISTRAR'S SIGNATURE Louisa M. Fisher
25. EMBALMER James D. Holman
LICENSE NO. E-516
FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5266
Local Reg. No. 1277
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 DEC 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
c. LENGTH OF STAY (in this place) 19 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedicts Nuseing Home 357

Bureau of Vital Sta

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell 83355
d. STREET ADDRESS (If rural, give location) 319 3rd ave. East

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) LOREN c. (Last) NELSON

4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1969

5. SEX Male

6. COLOR OR RACE w White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 20, 1900

9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Salem, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David Nelson
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Rosa Balentine
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 540-10-0207

17. INFORMANT'S OWN SIGNATURE Mrs Rhoda Chandler
ADDRESS Wendell

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of transverse colon — 1 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Benign Prostatic Hypertrophy 2 yr

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 - 8, 1968, *to* death, 19____, *that I last saw the deceased alive on* 11-22, 1969, *and that death occurred at* 3:50 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Harold F. Holsinger (Degree or title) MD 240

23b. ADDRESS Wendell, Idaho

23c. DATE SIGNED 12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE Nov. 28, 1969

24c. NAME OF CEMETERY OR CREMATORY Wendell Cemetery

24d. LOCATION (City, town, or county) (State) Wendell Idaho

DATE REC'D BY LOCAL REG. Dec. 5, 1969

REGISTRAR'S SIGNATURE Louella M. Scherer

25. EMBALMER Joe B. Leeper

LICENSE NO. E-530

FIRM NAME: Leeper Mortuary Wendell Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 7 1969 Bureau of Vital Statistics

State File No. 5267
Local Reg. No. 319
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene; LENGTH OF STAY (In this place) 1 hr.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location) 703 Appleway

3. NAME OF DECEASED (Type or Print)	a. (First) Earl	b. (Middle) R.	c. (Last) Harlowe	4. DATE OF DEATH (Month) (Day) (Year) November 2, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Oct. 25, 1912	9. AGE (In years last birthday) 57 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 28	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Texas	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Haynie Harlowe	BIRTHPLACE Nebraska	14. MOTHER'S MAIDEN NAME Patricia Woolsey	BIRTHPLACE Texas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (Be) Patricia Mallocks	ADDRESS Coeur d'Alene Idaho	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

150X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Carcinoma Esophagus	6 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Esophageal-bronchial fistula	6 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Carcinoma Esophagus	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* November 2, 19 69, *that I last saw the deceased alive on* November 2, 19 69, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE E. Thompson 530	(Degree or title) MD	23b. ADDRESS 920 Ironwood Dr. Coeur d Alene, Idaho	23c. DATE SIGNED 11-3-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov.6,1969	24c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park	24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho
DATE REC'D BY LOCAL REG. Nov 6, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. K. Riplinger Jr.	LICENSE NO. E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 3 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5268
Local Reg. No. 324
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Kootenai (28)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital (101)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Kootenai (28)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene

d. STREET ADDRESS (If rural, give location): 729 Gov't Way

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Marie		Brown	November 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Nov. 27, 1898	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Own Home	Colfax, Wash.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Phillips	(Unobtainable)	Elenorah Baird	Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-22-9979B	Harry J Brown	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Cardio-Vascular disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept. *, 19*69*, to* present *, 19*____*, that I last saw the deceased alive on* 11-3-69 *, 19*____*, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
(128) MD	920 Ironwood Drive, Coeur d'Alene	11-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-6-1969	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 10, 1969	Lorraine K. Brush	W. E. English	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5269
Local Reg. No. 332
Reg. Dist. No. 120

RECEIVED
NOV 21 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF RESIDENCE (In this place): 29 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 716 N. Third Street 02

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 716 N. Third Street

3. NAME OF DECEASED (Type or Print): a. (First) ALFRED; b. (Middle) C.; c. (Last) HANSEN

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 3, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 1/26/1889

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oil Distribution 26

10b. KIND OF BUSINESS OR INDUSTRY: Oil

11. BIRTHPLACE (State or foreign country): Minn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry J. Hansen — BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Bertha Bottolfson — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 516-07-9840

17. INFORMANT'S OWN SIGNATURE: Henry J. Hansen — ADDRESS: Bellview, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood, M.D. 583 (Degree or title) + Coroner

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 11-10-'69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/8/69

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Nov. 13, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland — LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 2 2 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 21 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5270
Local Reg. No. 334
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH 281
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 15 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 405 West Garden

3. NAME OF DECEASED (Type or Print)
a. (First) ELLA
b. (Middle) B.
c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year) Nov. 4, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May 30, 1883
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Bauld — BIRTHPLACE Scottland
14. MOTHER'S MAIDEN NAME Zura Reynolds — BIRTHPLACE Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 505-30-2240B
17. INFORMANT'S OWN SIGNATURE Mrs. Louis Ormesher Cd'A, ADDRESS Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 208X Art. sclerotic cardiovasc. disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Polycythemia vera. — 3 mo
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. hepatomegaly abdom. aneurysm

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-16, 1969, *to* 11-4, 1969, *that I last saw the deceased alive on* 11-4, 1969, *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Ferrand Barclay 025 (Degree or title)
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11-4-69
24c. NAME OF CEMETERY OR CREMATORY New Chicago Cemetery
24d. LOCATION (City, town, or county) (State) Drummond, Montana

DATE REC'D BY LOCAL REG. Nov. 20, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred Noland — LICENSE NO. E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5271
Local Reg. No. 320
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 7 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 281 Kootenai	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rathdrum
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000	d. STREET ADDRESS (If rural, give location) Rt. 1 Box 42

3. NAME OF DECEASED (Type or Print)	a. (First) Clark	b. (Middle) Lynn	c. (Last) Masterson	4. DATE OF DEATH (Month) Nov. (Day) 4, (Year) 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 7,1946	9. AGE (In years last birthday) 23	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 17	10b. KIND OF BUSINESS OR INDUSTRY Logging	11. BIRTHPLACE (State or foreign country) Montana	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lee B. Masterson	BIRTHPLACE Montana	14. MOTHER'S MAIDEN NAME Doris McNinch	BIRTHPLACE Montana		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) Army Reserves 8	16. SOCIAL SECURITY NO. 518-54-9460	17. INFORMANT'S OWN SIGNATURE X Judy M. Masterson	ADDRESS Rathdrum Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	accidental traumatism by	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	falling log.	Sudden
DUE TO (c)	Crushed Skull.	"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

916X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1 accident.	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Mill yard .09	21c. (CITY, TOWN, OR TOWNSHIP) 13280 (COUNTY) Coeur d'alene Kootenai	(STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-4-'69 9:00 A. m.	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? Log rolled off a truck.	

22. *I hereby certify that I attended the deceased from* Did not *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 583 4 (Degree or title) Coroner	23b. ADDRESS Coeur d'alene Idaho	23c. DATE SIGNED 11-5-'69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 8, 1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho
DATE REC'D BY LOCAL REG. Nov 6, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER N. F. Riplinger, Jr.	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 7 1969

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5272
Local Reg. No. 330
Reg. Dist. No. 120

BIRTH NOV 21 1969 69-10475

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY (in this place) 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hayden Lake Rural Route #2
d. STREET ADDRESS (If rural, give location) Box 125C

3. NAME OF DECEASED (Type or Print): a. (First) INFANT b. (Middle) BOY c. (Last) CARPENTER

4. DATE OF DEATH: (Month) (Day) (Year) Nov. 5, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 10/28/69
9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days: 7 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE 02
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Coeur d' Alene, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Glenn Carpenter BIRTHPLACE: Boise, Idaho
14. MOTHER'S MAIDEN NAME: Teresa King BIRTHPLACE: Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S OWN SIGNATURE Glen Carpenter ADDRESS Hayden Lk. Id. Rte.#2 Box 125C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1) PREMATURITY - 6-7 MONTHS GESTATION

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) 2) - INCOMPLETE EXPANSION OF LUNGS

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 9- DAYS.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/28/69, 19___, *to* 11/5/69, 19___, *that I last saw the deceased alive on* 11/5/69, 19___, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Lyle C. Fredrickson M.D.
23b. ADDRESS Coeur d' Alene, Idaho.
23c. DATE SIGNED 11/14/69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/10/69
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Frank Houde LICENSE NO.: E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended December 17, 1969

Certificate of Death
STATE OF IDAHO

State File No. 5273
Local Reg. No. 327
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Kootenai 28	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Oregon 38 b. COUNTY: Deschutes 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene c. LENGTH OF STAY (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bend
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location): 471 E. Clay

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Barbara	Ellen	Poland	November 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 2, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Iowa	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ulysses Grant Davis	Iowa	Mary Miller	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	541-60-0157	Mrs. Floy Cowgill	Bend, Oregon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonitis 486X — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Obesity - uremia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-3 , 19 69 , *to* 11-5-69 , 19 , *that I last saw the deceased alive on* 11-5-69 , 19 , *and that death occurred at* 11:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John M. Lanham, M.D. 602	Hayden Lake, Idaho	11-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Nov 6, 1969	Shaeffer Funeral Home	Payette, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 10-1969	Lorraine K. Brush	Bill Duff	E 439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel - Coeur d'Alene

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED

DEC 17 1969

Bureau of Vital Statistics

State of Idaho
County of Kootenai } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Barbara Ellen Poland (Name on Original Certificate) who died (Was Born or Died) on Nov 5, 1969 (Date of Event)
in Coeur d'Alene, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	Sept 2, 1887	September 2, 1888
Age	82	81

Subscribed and sworn to before me this 15th day of December, 1969

Notary Public, residing at Coeur d'Alene, Idaho
My commission expires 4-25-70
(Seal)

Signed Don C. English, Funeral Dir.
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1133 - 4th St - Cd'A Ida
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Kootenai } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 15th day of December, 1969

Notary Public, residing at Coeur d'Alene, Idaho
My commission expires 4-25-70
(Seal)

Signed Bill Wolff
(Signature of Any Credible Person)

(Street Address, City, State)

FORM DH 60-155

12-16-69

NOTARY
PUBLIC
STATE OF OHIO

Certificate of Death

STATE OF IDAHO

State File No. _____
Local Reg. No. 327
Reg. Dist. No. 120

BIRTH NO. _____

RECEIVED NOV 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Oregon
b. COUNTY: Deschutes
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bend
d. STREET ADDRESS (If rural, give location): 471 E. Clay

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Barbara	Ellen	Poland	November 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 2, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ulysses Grant Davis	Iowa	Mary Miller	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (RD) / ADDRESS
no / none	541-60-0157	Mrs. Flay Cowgill, Bend, Oregon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonitis	days -
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Obesity - uremia	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-3-69, 19, *to* 11-5-69, 19, *that I last saw the deceased alive on* 11-5-69, 19, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. M. Graham M.D.	Hayden Lake, Idaho	11-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Nov. 6, 1969	Shaeffer Funeral Home	Payette, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Lorraine K Brush	Bill Cauff	E-439

FIRM NAME: English Chapel - Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

[redacted]

DEC 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5274
Local Reg. No. 326
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace Nursing 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): Rt. #4 Box 296

3. NAME OF DECEASED (Type or Print): a. (First) Lawrence b. (Middle) A. c. (Last) Woods

4. DATE OF DEATH (Month) (Day) (Year): November 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 19, 1908	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operator 22	Own Store	Penoka, Albert-Canada	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable		Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	555-18-0483	X Mrs Irene L Woods	Coeur d'Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Papillary Transitional cell carcinoma of bladder, metastatic — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD, & angina
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
21 Jul 69	Ca of bladder	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 Jul, 19 69, *to* 5 Nov, 19 69, *that I last saw the deceased alive on* 3 Nov, 19 69, *and that death occurred at* 4:10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D	411 Coeur d'Alene Ave	6 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Nov. 7, 1969	Restlawn Memorial Park	Coeur d'Alene,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Lorraine K. Brush	[signature]	E397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH–63021

JAN 3 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5275
Local Reg. No. 323
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 25
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 6 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Terrace Nursing Home 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 25
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 921 Lakeside

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Earl	Bennett	November 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 20, 1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe Fitter 06	Kaiser Alum.	Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable	Unobtainable	Unobtainable	Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	519-03-7100	X Marion C. Shaffer	Wash. Newport

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Hypostatic pneumonia	1 week
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Senility and debility	6 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Chrobst pulm/emphysema	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb, 1969, to Nov 6, 1969, that I last saw the deceased alive on Nov 6, 1969, and that death occurred at 6:00 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
568 W. Wray Wilson MD	212 S 11th Coeur d Alene	11/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-8-1969	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 10, 1969	Lorraine K. Brush	Bill Neff	E-439

FIRM NAME: English Chapel Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5276
Local Reg. No. 329
Reg. Dist. No. 120

RECEIVED
NOV 21 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
LENGTH OF STAY (in this place) 7 Days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene Route #4

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 10

d. STREET ADDRESS (If rural, give location) Route #4 Box 348

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLINT	G.	BROWN	Nov. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	3/3/1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Kaiser All.	Kentucky	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Brown	UNKNOWN	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No NONE	518-14-5184A	Nell Brown	Route 4 Box 348 Coeur d' Alene, Idaho

4319

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS Multiple Sclerosis — 15 years
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. *, 19* 47 *, to* Nov. 9 *, 19* 69 *, that I last saw the deceased alive on* Nov 9 *, 19* 69 *, and that death occurred at* 10:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Reid Henson 225 M.D.	Coeur d'Alene Idaho	Nov 21 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/12/69	Forest Cemetery	Coeurd'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 17, 1969	Lorraine K. Brush	Fred Noland	E-493

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5277
Local Reg. No. 343
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
DEC 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): P. O. Box 153

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): E.
c. (Last): Cash

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 30, 1892
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Millwright 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Tomahawk, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Mark E. Cash — BIRTHPLACE: Tomahawk, Wisconsin
14. MOTHER'S MAIDEN NAME: Lizzie Meyers — BIRTHPLACE: Sheboygan, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 517-10-9391A
17. INFORMANT'S OWN SIGNATURE: Mabel Cash — ADDRESS: Bonners Ferry

4339

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic cerebrovascular disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic Brain Syndrome

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3, 19 69, *to* 11, 19 69 *that I last saw the deceased alive on* 10-5, 19 69, *and that death occurred at* 7 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. N. Lederblom M.D. 087
23b. ADDRESS: Hayden Lake, Idaho 83835
23c. DATE SIGNED: 11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 13
24b. DATE: Nov. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemtery
24d. LOCATION (City, town, or county) (State): Boundary County, Idaho

DATE REC'D BY LOCAL REG.: Nov. 21, 1969
REGISTRAR'S SIGNATURE: Lorraine K Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 21 1998

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 2 1 1969 Bureau of Vital Statistics

State File No. 5278
Local Reg. No. 335
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Terrace Nursing Home 340	d. STREET ADDRESS (If rural, give location) 826 N. 5th St.

3. NAME OF DECEASED (Type or Print) a. (First) Hilda	b. (Middle) Marie	c. (Last) Johnson	4. DATE OF DEATH (Month) (Day) (Year) November 9, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1895 November 29,	9. AGE (In years last birthday) 73; IF UNDER 1 YR. Months 11 Days 10; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Practical Nurse 13	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Sweden	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Nelson	BIRTHPLACE Sweden	14. MOTHER'S MAIDEN NAME Unobtainable	BIRTHPLACE Sweden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no; (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 519-44-2314A	17. INFORMANT'S OWN SIGNATURE Andrew Johnson (BE)	ADDRESS Post Falls, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer of Lung 1621 — INTERVAL BETWEEN ONSET AND DEATH 6-8 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1969	19b. MAJOR FINDINGS OF OPERATION Large Malignant Lung Tumor	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* Nov, 1969, *that I last saw the deceased alive on* Nov 7, 1969, *and that death occurred at* 12:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 746 (Degree or title)	23b. ADDRESS Coeur d'Alene Id	23c. DATE SIGNED 11/10/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE Nov. 13, 1969	24c. NAME OF CEMETERY OR CREMATORY Rockford Cemetery	24d. LOCATION (City, town, or county) (State) Rockford, Washington
DATE REC'D BY LOCAL REG. Nov. 13, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
NOV 12 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5279
Local Reg. No. 328
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) Rt #4 Box 210

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Russell	F.	Torkelson	Nov. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Aug. 23, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 24	Automobiles	Minnesota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable		Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
no none	567-10-8270	Adele G. Torkelson Coeur d'Alene, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1519 Adenocarcinoma, stomach — INTERVAL BETWEEN ONSET AND DEATH: 1965

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with recurrance.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	gastric Resection 1965 Dr. G.E. Schnegg. Spokane Wash	Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-7-69, 19__, *to* 11-9, 1969, *that I last saw the deceased alive on* 11-8, 1969, *and that death occurred at* 3 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M Douglas 25 MD	Coeur D'Alene Idaho	11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 12, 1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 10, 1969	Lorraine K. Brush	Bill Neff	E-439

FIRM NAME English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5280
Local Reg. No. 339
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
NOV 21 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY IN (this place) 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 1222 C Street

3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) c. (Last) VECKMAN

4. DATE OF DEATH (Month) (Day) (Year) Nov. 9, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 3/1/1889

9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner 07

10b. KIND OF BUSINESS OR INDUSTRY Coal Mining

11. BIRTHPLACE (State or foreign country) Belgium

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN BIRTHPLACE UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE

16. SOCIAL SECURITY NO. 537-01-8916

17. INFORMANT'S OWN SIGNATURE 1222 C St. ADDRESS Pearl Veckman Coeur d' Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH 14 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 4 years
DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bleeding duodenal ulcer — 4-5 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 9.27.65 ~~19~~, *to* 11-9, 1969, *that I last saw the deceased alive on* 11-8, 19 69, *and that death occurred at* 7:40A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Coeur d' Alene

23c. DATE SIGNED 11.10.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/11/69

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Nov. 13, 1969

REGISTRAR'S SIGNATURE Lorraine K Brush

25. EMBALMER Fred Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5281
Local Reg. No. 345
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 DEC 4 1969
b. CITY OR TOWN Athol
LENGTH OF STAY (in this place) 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route #1 Box 71

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Athol
d. STREET ADDRESS (If rural, give location) Route #1 Box 71

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MICHAEL	JOHN	DE BERNARDI	Nov. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	4/15/1895	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ran Steam Bath 26	Steam Bath House	Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3		Joyce De Bernardi	Route #1 Box 71 Athol, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Unknown Disease	Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Probable Coronary occlusion	"
DUE TO (c)		
II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		Probable Heart attack

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 583 Coroner	Coeur d'Alene Idaho	11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/14/69	Restlawn Memorial Pk.	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21, 1969	Lorraine K. Brush	Frank Houde	E-521

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 10 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 6 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 13 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 21 1969
Bureau of Vital Statistics

State File No. 5282
Local Reg. No. 333
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 2820 N. 7th St.

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) Irl
c. (Last) Hogg

4. DATE OF DEATH (Month) (Day) (Year) November 12, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 4,1892
9. AGE (In years last birthday) 77
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman 06
10b. KIND OF BUSINESS OR INDUSTRY Kaiser Aluminum
11. BIRTHPLACE (State or foreign country) Unionville, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Johnathen Hogg
BIRTHPLACE Montana
14. MOTHER'S MAIDEN NAME Sarah Alexander
BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) W. W. I 3
16. SOCIAL SECURITY NO. 518-03-9786
17. INFORMANT'S OWN SIGNATURE (SC) Elizabeth Hogg
ADDRESS Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4442

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Thrombosis Superior

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) mesenteric artery
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Cardio

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION vascular disease
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1951, *to* _____, 1969, *that I last saw the deceased alive on* Nov 12, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Donald M Gunnerbel 192 (Degree or title) MD
23b. ADDRESS 502 W 5 St
23c. DATE SIGNED 14 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov.15,1969
24c. NAME OF CEMETERY OR CREMATORY Restlawn Park
24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. Nov.17,1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 1 1969

NOV 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 2 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5283
Local Reg. No. 336
Reg. Dist. No. 120

BIRTH NO.

NOV 21 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kootenai
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Terrace Nursing Home 340	d. STREET ADDRESS (If rural, give location) 721 Lakeside

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Charles	F.	Keane	November 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
Male	White	Married	Feb. 13,1876	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber 21		Boston, Mass.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable		Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (BC)	ADDRESS
no	none	533-20-8939	Eugene McDonald	Coeurd'Alene

4369

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Vascular Accident	1 hour.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized Arteriosclerosis	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Gangrene left foot	3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-12, 1969, *to* 11-12, 1969, *that I last saw the deceased alive on* 11-12, 1969, *and that death occurred at* 1:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. E. Thompson 530	MD	920 Ironwood Dr, Coeur d Alene Idaho	11-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-15-1969	St. Thomas Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 17, 1969	Lorraine R. Brush	N. F. Riplinger Jr.	E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5284
Local Reg. No. 338
Reg. Dist. No. 120

RECEIVED NOV 21 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY (In this place) 12 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 818 Second Street

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH
b. (Middle) E.
c. (Last) MILLER

4. DATE OF DEATH (Month) (Day) (Year) Nov. 12, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 2/11/1888

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Michigan

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN
BIRTHPLACE UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN
BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-12-8365

17. INFORMANT'S OWN SIGNATURE Josephine Robins
ADDRESS Coeur d' Alene Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4109 Acute Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ASHD

DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 128 (Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/15/69

24c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Pk.

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Nov 17, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Frank Houde
LICENSE NO. E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5285
Local Reg. No. 337
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 21 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY (In this place) Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 424 Foster Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	FREDA	E.	COOPER	Nov. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	9/21/1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Superior, Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		W. K. Kobs	Coeur d' Alene, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Chronic Myocarditis	10 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pulmonary Congestion Senility	2 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb., 1962, *to* Nov. 13, 1969, *that I last saw the deceased alive on* Nov. 13, 1969, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Rex Benson 325	M.D.	Coeur d'Alene Idaho	Nov. 19, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11/17/69	Forest Lawn Cemetery	Los Angeles, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 20, 1969	Lorraine K. Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 28 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5286
Local Reg. No. 337
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Kootenai — NOV 21 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place): 2 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene,
d. STREET ADDRESS (If rural, give location): 721 Eight Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARY	L.	LANEY	Nov. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Never Married	1/7/1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher	Public Schools	Penn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Laney	Penn.	Lydia Kinter	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-36-3882	Mildred Olsen	Coeur d' Alene, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Coronary Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* Nov 14, 19 69, *that I last saw the deceased alive on* Nov 7, 19 69, *and that death occurred at* 9:4 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	502 N 5th	20 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/18/69	Restlawn Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 20, 1969	Lorraine K. Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 2 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 2 2 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 2 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR - 7 1990

MAR 1 3 1990

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

DEC 4 1969

Bureau of Vital Statistics

State File No. 5287
Local Reg. No. 346
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print): a. (First) Adrian b. (Middle) Hugh c. (Last) FOTHERGILL

4. DATE OF DEATH (Month) (Day) (Year): November 18, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 6, 1907

9. AGE (In years last birthday): 62
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Kaiser Aluminum Trentwood

11. BIRTHPLACE (State or foreign country): Rambler, Wyoming

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James C. Fothergill
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Josephine Cunningham
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-II

16. SOCIAL SECURITY NO.: 518-01-9360

17. INFORMANT'S OWN SIGNATURE: X Esther M. Fothergill
ADDRESS: Post Falls Idaho RT 1 83854

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Residual of old Stroke

4319

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 15-1968, 19__, to Nov 18, 19 69, *that I last saw the deceased alive on* Nov 18, 19 69, *and that death occurred at* 7:20 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 11/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: 11/21/69

24c. NAME OF CEMETERY OR CREMATORY: Hazen & Jaeger Funeral Home

24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: Dec 2 1969

REGISTRAR'S SIGNATURE: Lorraine K Brush

25. EMBALMER: S. E. Eckman

LICENSE NO.: 91896 wash.

FIRM NAME: Hazen & Jaeger Funeral Homes, Inc.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5288
Local Reg. No. 347
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
DEC 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 212 3rd St. 000	d. STREET ADDRESS (If rural, give location) 320 Military Drive

3. NAME OF DECEASED (Type or Print)	a. (First) Albert	b. (Middle) H.	c. (Last) Knudson	4. DATE OF DEATH (Month) (Day) (Year) November 18, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 14,1889	9. AGE (In years last birthday) 80 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner 22	10b. KIND OF BUSINESS OR INDUSTRY Knudson Feed Store	11. BIRTHPLACE (State or foreign country) Post Falls, Ida.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unobtainable	BIRTHPLACE Norway	14. MOTHER'S MAIDEN NAME Unobtainable	BIRTHPLACE Norway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) W. W. I 3	16. SOCIAL SECURITY NO. 518-16-9900	17. INFORMANT'S OWN SIGNATURE X Robert H Knudson	ADDRESS Spokane

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

9529

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Suicide by cyanide — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ~~ACCIDENT~~ SUICIDE ~~HOMICIDE~~ (Specify) Suicide	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) apartment 32	21c. (CITY, TOWN, OR TOWNSHIP) Coeur d'alene 1328 (COUNTY) Kootenai	(STATE) Idaho.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-18-'69 1 P. m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Poured out cyanogas.	

22. *I hereby certify that I attended the deceased from* Did not. *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 583 (Degree or title) Coroner	23b. ADDRESS Coeur d'alene Idaho	23c. DATE SIGNED 11-21-'69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov.21,1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho
DATE REC'D BY LOCAL REG. Nov. 21, 1969	REGISTRAR'S SIGNATURE Lorraine K Brush	25. EMBALMER N. F. Riplinger Jr.	LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Funeral Chapel-CDA, Ida

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969
JAN 16 1970
JAN 20 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5289
Local Reg. No. 256
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 781
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene,
c. LENGTH OF STAY (in this place): Seconds
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Int. St. 90 at N.W. Blvd. 642

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Arkansas 04
b. COUNTY: Johnson 535
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Route 3 Clarksville
d. STREET ADDRESS (If rural, give location): Rural Route #3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Donald	Ray	Allen	Nov. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	9/17/37	32				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Auto	Arkansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leo Allen	UNKNOWN	Blanche Blevins	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	NONE	430-66-4024	Blanche Allen	612 Brown St. Clarksville, Ark.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	accidental Traumatism due	sudden
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	to automobile - pedestrian accident	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	multiple crush injuries	"

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	Hiway 90 06	Coeur d'alene Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY occur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Struck by a car on off Ramp of Freeeway

22. *I hereby certify that I attended the deceased from* Did not ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 583 4 Coroner	Coeur d'alene Idaho	12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11/23/69	Cox Funeral home	Clarksville, Arkansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4, 1969	Lorraine K. Brush	Frank Houde	E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 7 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 4 1969 Bureau of Vital Statistics

State File No. 5290
Local Reg. No. 344
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Kootenai	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho 13 b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF STAY (If outside place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Coeur d' Alene Homes 103	d. STREET ADDRESS (If rural, give location) Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print) a. (First) Eleanor	b. (Middle)	c. (Last) Cathcart	4. DATE OF DEATH (Month) (Day) (Year) November 21, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 12, 1885	9. AGE (In years last birthday) 84 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Shelby County, Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Higgins	BIRTHPLACE Ohio	14. MOTHER'S MAIDEN NAME Eliza Barkalow	BIRTHPLACE Ohio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 518-03-0382	17. INFORMANT'S OWN SIGNATURE x Ruth R. Elliott	ADDRESS Lompoc Calif.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Vascular Thrombosis	days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	General & Cerebral Arteriosclerosis	Years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Urinary Infection + Retention	days

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify) —	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 3, 1968, *to* Nov 21, 1969, *that I last saw the deceased alive on* Nov 19, 1969, *and that death occurred at* 7:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE Shelby H. Higgins 313	(Degree or title) M.D.	23b. ADDRESS 411 Coeur d'Alene Ave, CDA Ida	23c. DATE SIGNED Nov. 21, '69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 24, 1969	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho
DATE REC'D BY LOCAL REG. Dec. 1, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
DEC 4 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5291
Local Reg. No. 240
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101	d. STREET ADDRESS (If rural, give location): 1042 N. 14th St.

3. NAME OF DECEASED (Type or Print) a. (First): Ray	b. (Middle): R.	c. (Last): Anderson	4. DATE OF DEATH (Month) (Day) (Year): Nov. 23, 1969		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Aug. 12, 1910	9. AGE (In years last birthday): 59	IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance 17	10b. KIND OF BUSINESS OR INDUSTRY: Lumber Mill	11. BIRTHPLACE (State or foreign country): Michigan	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: August Anderson	BIRTHPLACE: Finneland	14. MOTHER'S MAIDEN NAME: Clara K. Engelholm	BIRTHPLACE: Finneland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none	16. SOCIAL SECURITY NO.: 537-10-9280	17. INFORMANT'S OWN SIGNATURE: ✓ Bruce O. Anderson	ADDRESS: Coeurd'Alen		

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute myocardial infarction	Days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary atherosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Adeno-carcinoma of prostate	Months

19a. DATE OF OPERATION: 19 Sep 69	19b. MAJOR FINDINGS OF OPERATION: Prostatic tumor invading bladder	20. AUTOPSY? Yes ☑ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 16 Sep, 1969, *to* 23 Nov, 1969, *that I last saw the deceased alive on* 23 Nov, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Robert H Young, M.D 786 (Degree or title)	23b. ADDRESS: 411 Coeur d'Alene Ave	23c. DATE SIGNED: 24 Nov 69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Nov. 26, 1969	24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county): Coeur d'Alene, (State): Idaho		
DATE REC'D BY LOCAL REG.: Dec 1, 1969	REGISTRAR'S SIGNATURE: Lorraine K Brush	25. EMBALMER: N. F. Griplinger Jr.
LICENSE NO.: E-397		

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 8 1969

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5292
Local Reg. No. 341
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 207 E. Garden

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Millie	E.	Barry	Nov. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	April 5, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Hayes	Ill.	Charlotte Anthony	Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	483-05-6110B	Doney Sutton	Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Edusta Cardio vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec. 1961, 19____, *to* present, 19____, *that I last saw the deceased alive on* 11-25-69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] 28 (Degree or title)	920 Ironwood Dr. Coeur d'Alene, Idaho	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 29, 1969	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Lorraine K. Brush	[signature]	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5293
Local Reg. No. 342
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 219 Sherman Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Frank	L.	Burke	November 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Jan. 25, 1910	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager 26	Shamrock Bar	Spokane, Wash.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank L. Burke	Idaho	Ellen Dollen	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no / none	539-07-7097	Beverly Lee Bakken	Spokane

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cor Pulmonale

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Emphysema
DUE TO (c) Chronic Lung Disease.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-19-69 , 19____ , *to* present , 19____ , *that I last saw the deceased alive on* 11-25-69 , 19____ , *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 128	920 Ironwood Dr. Coeur d'Alene	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 29, 1969	St. Thomas Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Lorraine K. Brush	M. E. Tiplinger	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 4 1969
DEC 9 1969
DEC 11 1969
DEC 22 1969
JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5294
Local Reg. No. 348
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hopsital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 963 6th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Herman	C.	Ostermeyer	November 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 18, 1899	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Front end Alignment 21	Auto Repair	Germany	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Ostermeyer	Germany	Josephine (Unobt.)	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-01-2637	Sarah H Ostermeyer	Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Asthoi C.F.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cor Pulmonale
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Emphysema

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 1963, 19____, *to* present, 19____, *that I last saw the deceased alive on* 11-25-69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 128	920 Ironwood Dr. Coeur d'Alene Idaho	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation 3	11-29-69	Moon's Crematory	Sandpoint, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 2, 1969	Lorraine K. Brush	[signature]	E-439

FIRM NAME English Chapel-Coeur d' Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 4 1969

APR 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5295
Local Reg. No. 349
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 4 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

c. LENGTH OF STAY (In this place) 2 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Kootenai 28

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

d. STREET ADDRESS (If rural, give location) P. O. Box 243 (Dalton Garden)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Rex	P.	Pollock	November 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 18, 1908	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mining 07	Silver Mines	Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wm. W. Pollock	Utah	Zina Ett Parker	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	none	518-03-1247	X Mrs Ira E. Pollock	Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial Infarction

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) AS #10

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Lung disease.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec. 1961, 19____, to present, 19____, that I last saw the deceased alive on 11-25-69, 19____, and that death occurred at ____m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
MD	920 Ironwood Dr. Coeur d'Alene Idaho	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 29,69	Restlawn Memorial Pk.	Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Lorraine K Brush	Bill Cluff	E-439

FIRM NAME: English Chapel-CDA, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969
FEB 10 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 16 1969 Bureau of Vital Statistics

State File No. 5296
Local Reg. No. 258
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH — 280
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Harrison
c. LENGTH OF STAY (In this place) Sec.
d. FULL NAME OF HOSPITAL OR INSTITUTION 4 Mi. N. Harrison on Hi. 95A

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) — 280
a. STATE Idaho
b. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Harrison, Idaho
d. STREET ADDRESS (If rural, give location) Route #2 Carlin Bay

3. NAME OF DECEASED (Type or Print) a. (First) ALVIN b. (Middle) HOWARD c. (Last) MC CUISTION
4. DATE OF DEATH (Month) (Day) (Year) Nov. 28, 1969
5. SEX Male
6. COLOR OR RACE Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 4/26/15
9. AGE (In years last birthday) 54 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) California
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Arthur Mc Cuistion — BIRTHPLACE UNKNOWN
14. MOTHER'S MAIDEN NAME Ethel Craig — BIRTHPLACE Wisconsin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 527-30-8559
17. INFORMANT'S OWN SIGNATURE Jane Mc Cuistion — ADDRESS Rt. 2 CarlinBay, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — 965X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Homicide by firearms — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 30-30 Bullet wound of head — INTERVAL BETWEEN ONSET AND DEATH: "
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Homicide 3
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) farm 31
21c. (CITY, TOWN, OR TOWNSHIP) Rural Harrison (COUNTY) Kootenai (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Shot by 30-30 rifle.

22. *I hereby certify that I attended the deceased from* Did not , 19____ , to ____ , 19____ , *that I last saw the deceased alive on* ____ , 19____ , *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 533 (Degree or title) Coroner
23b. ADDRESS Coeur d'Alene, Idaho
23c. DATE SIGNED 12-9-'69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/11/69
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Dec 9, 1969
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER Fred Noland
LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH--63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 16 1969

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DEC 7 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5297
Local Reg. No. 260
Reg. Dist. No. 120

RECEIVED
Bureau of Vital Statistics
DEC 16 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 107

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d ' Alene
d. STREET ADDRESS (If rural, give location): 702 Indiana Avenue

3. NAME OF DECEASED (Type or Print): a. (First) ZETTA; b. (Middle); c. (Last) RHODES

4. DATE OF DEATH (Month) (Day) (Year): Nov. 30, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 9/27/1883

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Detriot Lakes, Minn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elias Hanson
BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: UNKNOWN
BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-09-5926

17. INFORMANT'S OWN SIGNATURE: W. C. Rhodes
ADDRESS: Coeur d' Alene, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: C E Thompson 530 (Degree or title) MD
23b. ADDRESS: 920 Ironwood Dr. Coeur d Alene Idaho
23c. DATE SIGNED: 12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 12/3/69
24c. NAME OF CEMETERY OR CREMATORY: Fairmont Cemetery
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: Dec 9, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5298
Local Reg. No. 125
Reg. Dist. No. 200

BIRTH NO.

RECEIVED NOV 17 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): 48 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 miles N. of Potlatch ooo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
d. STREET ADDRESS (If rural, give location): 5 miles N. Of Potlatch

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRED	PALMER	NOWACK	November 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	9-1-21	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter 21		Colfax, Washington	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leo Nowack	Idaho	Lora McCown	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 10 4497	Clio Nowack	Rt. 1, Potlatch, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4709 acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease
DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—	—	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4-3-, 19[illegible], *to* 11-6-, 19[illegible], *that I last saw the deceased alive on* 10-18-, 1969, *and that death occurred at* 7:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Geoff E. Wilson	M.D.	Moscow Idaho	11-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-10-69	Freeze Cemetery	Latah County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
13 Nov 1969	Wayne R Heiskari	E. A. Ellithorpe	1280

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Kimball Funeral Home, Palouse, Wa.

DUTIES:

NOV 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 18 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5299
Local Reg. No. 130
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 3 1969 Bureau of Vital Stat.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): All Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 903 East 5th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 903 East 5th

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Thomas
c. (Last): Posey

4. DATE OF DEATH (Month) (Day) (Year): Approx. 11 10 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: January 14, 1911
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City Employee 08
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Wilber Poesy — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Mary Belle Hornered — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W.W.-2 +
16. SOCIAL SECURITY NO.: 519-03-5321
17. INFORMANT'S OWN SIGNATURE: Mrs. Marie McLaughlin — ADDRESS: 324-4th Lewiston

4310

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): hypertension — ?
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. B. Fritzmann M. Coroner 057
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 24 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-25-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 26 Nov 1969
REGISTRAR'S SIGNATURE: Wayne R. Hirskoir
25. EMBALMER: E. Pete Albertson — LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician

Body discovered March 18, 1969 in Home.

M. Hickam, Registrar

State File No. 5300
Local Reg. No. 126
Reg. Dist. No. 200

Certificate of Death

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

BIRTH NO.

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF DEATH (If not in this place): 4 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 432 Lewis

3. NAME OF DECEASED (Type or Print)
a. (First): Minnie
b. (Middle): Eid
c. (Last): Olson

4. DATE OF DEATH (Month) (Day) (Year): November 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: September 29, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): La Cuosse, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lars Eid — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Tolena Unknown — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-09-5521
17. INFORMANT'S OWN SIGNATURE: Mrs. Darlene W. Smith — ADDRESS:

18. CAUSE OF DEATH 4409
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 1-3 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis generalized — yes
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Nov., 1969, *that I last saw the deceased alive on* Nov. 10, 1969, *and that death occurred at* 6:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward [illegible] 788 [illegible]
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 11-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-13-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 17 Nov 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: E. Pete Albertson — LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5301
Local Reg. No. 127 9-69
Reg. Dist. No. 290

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) on the way to Spokane, Wn.
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) in Ambulance

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 430 East A

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	James	Elmer	Wood	Nov. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 14, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Agriculture	Moscow, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew W. Wood	Missouri	Lucy A. Hawley	Greenville, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I	518-40-7944	Mary R. Wood	Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Fat Embolism — INTERVAL BETWEEN ONSET AND DEATH: Minute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Compound, Comminuted fracture of Rt. distal femur — 2 hrs.

DUE TO (c) Accident - Falling Tree — 2 hrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cerebral Contusion
Fractured ribs — 2 hrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Home	Moscow Latah 13291 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
November 13 1969 4:15 P.m.		Tree Fell

22. I hereby certify that I attended the deceased from _____, 196_, to Nov. 13, 1969, that I last saw the deceased alive on Nov. 13, 1969, and that death occurred at 6:32 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 058 M.D.	Moscow Idaho	11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 18, 1969	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
21 Nov 1969	Wayne R Heiskari	Ronald Ward	E-80

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 17 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5302
Local Reg. No. 128
Reg. Dist. No. 200

RECEIVED
DEC 3 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Moscow
LENGTH OF STAY (in this place): 2 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: LaTAH 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 619 Kenneth

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Louis	Victor	Olsen	November 15 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	October 9, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter & Paper Hanger 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Denmark
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Johan Olsen	Denmark	Julia Unknown	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 533-03-3397-D
17. INFORMANT'S OWN SIGNATURE: x Steven J. Watson — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1967, to Nov 15, 1969, *that I last saw the deceased alive on* Nov 15, 1969, *and that death occurred at* 10:04 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W J Adams 001 MD	Moscow, Idaho	11/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-20-1969	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
24 Nov 1969	Wayne R Hiskari	E. Pete Albertson	E-525

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL - 8 1986

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 3 1988

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate,

MAR 04 1999

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5303
Local Reg. No. 129
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Latah 241
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 3 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latah Convalescent Center 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Juliaetta
d. STREET ADDRESS (If rural, give location) Juliaetta, Idaho

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	Claude	Byron	Browning

4. DATE OF DEATH (Month) (Day) (Year): November 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	January 13, 1883	86	10	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman 10	Milwaukee Railroad	Marionville, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Browning	Missouri	Susan Irwin	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	707-18-3673A	X Mrs Monte C. Calkins	Juliaetta, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Nov. 16, 1969, *that I last saw the deceased alive on* Nov. 15, 1969, *and that death occurred at* 6:15 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward H Boat	MD	Moscow Idaho	11-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 20, 1969	Lewis-Clark Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
24 Nov 1969	Wayne R Heiskari	Donald Ward	E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED DEC 8 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5304
Local Reg. No. 131
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 2days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Whitman 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Uniontown
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) c. (Last) Warnecke

4. DATE OF DEATH (Month) Nov. (Day) 18 (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb. 6. 1889
9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Glencoe, Minn
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Theodore Warnecke BIRTHPLACE Glendorif, Ohio
14. MOTHER'S MAIDEN NAME Katherine Verhoff BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 538-36-7631
17. INFORMANT'S OWN SIGNATURE ADDRESS Genesee, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Arteriosclerotic Heart Disease — yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1969, *to* Nov. 18, 1969, *that I last saw the deceased alive on* Nov. 18, 1969, *and that death occurred at* 2:25 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 058 (Degree or title) M.D.
23b. ADDRESS Moscow, Idaho
23c. DATE SIGNED 12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY Uniontown Catholic Cemetery
24d. LOCATION (City, town, or county) (State) Uniontown, Wash,

DATE REC'D BY LOCAL REG. Dec. 2, 1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER V. Vassar
LICENSE NO. E 297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5305
Local Reg. No. 135
Reg. Dist. No. 200

RECEIVED DEC 8 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 3 Miles N. Moscow
c. LENGTH OF STAY (in this place): Seconds
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Highway 95 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Jacquline
b. (Middle): Pauline
c. (Last): Mundell

4. DATE OF DEATH (Month) 11 (Day) 23 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: August 23, 1966
9. AGE (In years last birthday): 3 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Steven Mundell — BIRTHPLACE: Carson City, Colorado
14. MOTHER'S MAIDEN NAME: Carolyn Rae Breeze — BIRTHPLACE: Clarkston, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Clayton Zolber — ADDRESS: RI Troy Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) brain laceration — INTERVAL BETWEEN ONSET AND DEATH: immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) skull fracture - massive
DUE TO (c) car accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): US Hwy 95 06
21c. (CITY, TOWN, OR TOWNSHIP) 13290 (COUNTY) (STATE): 3 mi N Moscow Latah Idaho

21d. TIME OF INJURY (Month) 11 (Day) 23 (Year) 69 (Hour) 2 pm. 30
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? car accident

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Fritzmann 583 Coroner
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 11/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-26-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: Dec. 2, 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: Donald Ward — LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

DUTIES:

DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5306
Local Reg. No. 138
Reg. Dist. No. 200

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 241 — DEC 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (In this place): 3 ½ Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 12

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print): a. (First) James — b. (Middle) Nevelle — c. (Last) Mundell

4. DATE OF DEATH: (Month) 11 (Day) 23 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: May 27, 1964

9. AGE (In years last birthday): 5 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Moscow, Idaho

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Steven Mundell — BIRTHPLACE: Carson City Colorado

14. MOTHER'S MAIDEN NAME: Carolyn Rae Breeze — BIRTHPLACE: Clarkston, Wash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Clayton Zolker RT Troy Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Compressed Skull fracture — INTERVAL BETWEEN ONSET AND DEATH: 2 ½ hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13290 Latah, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 23, 1969 3:30 PM

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Auto Accident

22. *I hereby certify that I attended the deceased from* 11/23/69, 19___, *to* 11/27/69, 19___, *that I last saw the deceased alive on* 11/23/69, 19___, *and that death occurred at* 6:06 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: D Sadams MD 001 (Degree or title)

23b. ADDRESS: Moscow, Idaho

23c. DATE SIGNED: 11/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-26-1969

24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery

24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: Dec. 3, 1969

REGISTRAR'S SIGNATURE: Wayne R Heiskari

25. EMBALMER: E. Pete Albertson — LICENSE NO.: E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5307
Local Reg. No. 136
Reg. Dist. No. 200

BIRTH NO.

RECEIVED Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 290 DEC 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 3 Miles N. of Moscow
c. LENGTH OF STAY (In this place): Seconds
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Highway 95 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Kurt	Allen	Mundell	11	23	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	August 28, 1967	2				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Steven Mundell	Carson City, Colorado	Carolyn Rae Breeze	Clarkston, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Clayton Zolber RT Troy Idaho	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) skull fracture massive
DUE TO (c) car accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
/	US Hiway 95	3 mi N Moscow	Latah	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐	NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
11	23	69	2:30 p.m.			car accident

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 4		11/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-26-1969	Moscow Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 3, 1969	Wayne R Heiskari	Donald Ward	E-30

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

DUTIES:

DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5308
Local Reg. No. 134
Reg. Dist. No. 200

RECEIVED DEC 8 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 3 Miles N. Moscow-Hi. 95
c. LENGTH OF STAY (in this place): Seconds
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Highway 95 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Whitman 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pullman
d. STREET ADDRESS (If rural, give location): Campus Trailor Court

3. NAME OF DECEASED (Type or Print)
a. (First): Roberta
b. (Middle): Nadine
c. (Last): Mundell

4. DATE OF DEATH (Month) (Day) (Year): November 23 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: January 31, 1935
9. AGE (In years last birthday): 34 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Paul Kimberling — BIRTHPLACE: Blane County Virg.
14. MOTHER'S MAIDEN NAME: Ruth Taylor — BIRTHPLACE: Potlatch, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-46-6946
17. INFORMANT'S OWN SIGNATURE: Clayton Zolber — ADDRESS: RI tray Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): obstructed airway — INTERVAL BETWEEN ONSET AND DEATH: immed

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): fracture mandible

DUE TO (c): car accident

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: hemothorax 2° rib fracture multiple lacerations

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): ✓
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): US Hwy 95 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 3 mi N. Moscow 13290 Latah Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 23 69 2:30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: car accident

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Fritzmann 583 Coroner
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 11/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-26-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: Dec. 3, 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.-

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-5014

BIRTH NO.

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5309
Local Reg. No. 137
Reg. Dist. No. 200

1. PLACE OF DEATH
a. COUNTY: Latah 291 DEC 8 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 17 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 1.12

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Vance
b. (Middle): Rae
c. (Last): Mundell

4. DATE OF DEATH (Month) 11 (Day) 23 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: May 16, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 6 Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Steven Mundell — BIRTHPLACE: Carson City, Colorado
14. MOTHER'S MAIDEN NAME: Carolyn Rae Breeze — BIRTHPLACE: Clarkston, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Clayton Zolber — ADDRESS: RI Troy Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Compressed Skull fracture — INTERVAL BETWEEN ONSET AND DEATH: immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): ✓
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hiway 95 N. 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Moscow 13290 Latah Idaho
21d. TIME OF INJURY (Month) 11 (Day) 23 (Year) 69 (Hour) 2:20 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Car accident

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 583 4 Gritzmann M Coroner
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 11/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-26-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: Dec. 3. 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskii
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

DUTIES:

DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5310
Local Reg. No. 133
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 8 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) Few Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Alpha Chi Omega U. of I. Campus 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 909 South Washington

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) Helen
c. (Last) Kasper

4. DATE OF DEATH (Month) 11 (Day) 24 (Year) 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May 28, 1902
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pullman, Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jack Koppel — BIRTHPLACE Switzerland
14. MOTHER'S MAIDEN NAME Louise Friedly — BIRTHPLACE Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-14-4430
17. INFORMANT'S OWN SIGNATURE x Gilbert W. Baty — ADDRESS Haden Lake, Idaho

4360

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH none

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. *, 19*69*, to* Nov. *, 19*69*, that I last saw the deceased alive on* Nov. 20 *, 19*69*, and that death occurred at* 10:50 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE Edward Boas 788 (Degree or title) MD
23b. ADDRESS Moscow Idaho
23c. DATE SIGNED 11-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-28-1969
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 2, 1969
REGISTRAR'S SIGNATURE Wayne R Hinkari
25. EMBALMER E. Pete Albertson
LICENSE NO. E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5311
Local Reg. No. 142
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 8 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah Convalescent Center 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Juliaetta
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Lloyd
c. (Last): Candler

4. DATE OF DEATH (Month) (Day) (Year): Nov. 25, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 3, 1880
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Marshall North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles B. Candler — BIRTHPLACE: North Carolina
14. MOTHER'S MAIDEN NAME: Matilda Treadaway — BIRTHPLACE: North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-03-2248
17. INFORMANT'S OWN SIGNATURE: Donald B Candler — ADDRESS: Bovill, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart 4123
ANTECEDENT CAUSES — Disease with auricular
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): fibrillation
DUE TO (c): Cerebral Embolus left
II. OTHER SIGNIFICANT CONDITIONS — Brain Paralysis
Conditions contributing to the death but not related to the disease or condition causing death. Night sick

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19-, 1969, *to* 11-25-, 1969, *that I last saw the deceased alive on* 11-22-, 1969, *and that death occurred at* 10:05 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 567
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 12-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: Tekean Cemetery
24d. LOCATION (City, town, or county) (State): Latah Co. Idaho

DATE REC'D BY LOCAL REG.: 12/10/69
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: Donald Ward — LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5312
Local Reg. No. 132
Reg. Dist. No. 200

RECEIVED DEC 8 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman General Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kendrick
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) ALEXANDER
b. (Middle) nmi
c. (Last) LARSON

4. DATE OF DEATH (Month) (Day) (Year) 25 November 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 7 January 1896
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain
11. BIRTHPLACE (State or foreign country) Black Diamond, Washington
12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Emil Larson — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Marie Keopp — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW-1 3
16. SOCIAL SECURITY NO. 519 42 2987
17. INFORMANT'S OWN SIGNATURE Allie M. Larson — ADDRESS Kendrick, Idaho

7845

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) unknown.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Old ulcer deformity 2 yrs prior
Heart block severe & congestive failure years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1968, *to* 11-25, 1969, *that I last saw the deceased alive on* 11-24, 1969, *and that death occurred at* 3:15 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE Omer H Drury 148 (Degree or title) MD.
23b. ADDRESS Troy Idaho
23c. DATE SIGNED 11-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal/Burial
24b. DATE, Burial 29 Nov 1969
24c. NAME OF CEMETERY OR CREMATORY Leland Cemetery
24d. LOCATION (City, town, or county) (State) Leland, NezPerce Co., Idaho

DATE REC'D BY LOCAL REG. Dec. 2, 1969
REGISTRAR'S SIGNATURE Mayne R Heiskin
25. EMBALMER W E Black — LICENSE NO. E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5313
Local Reg. No. 140
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 16 1969
Bureau of Vital Stat.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah County Nursing Home 115

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harvard
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Isaac
b. (Middle): Gordon
c. (Last): Forstrom

4. DATE OF DEATH (Month) (Day) (Year): November 28, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 2, 1894
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: General Labor
11. BIRTHPLACE (State or foreign country): Sarad Coulee, Montana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Forstrom — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Elizabeth Luoma — BIRTHPLACE: Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 702-01-3007
17. INFORMANT'S OWN SIGNATURE: X Mrs. Signa Thompson — ADDRESS: Cover D' Alene

18. CAUSE OF DEATH 885X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fractured humerus — 7 months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XXX SUICIDE HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Latah Convalescent Center
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Moscow 13291 Latah Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 16, 1969-1:30
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Slipped in bathroom falling & breaking arm

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Nov. 28, 1969, *that I last saw the deceased alive on* Nov. 26, 1969, *and that death occurred at* 11:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edward L. Boas 788 (Degree or title) MD
23b. ADDRESS: Prof. Bldg. Moscow Idaho
23c. DATE SIGNED: 12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 2, 1969
24c. NAME OF CEMETERY OR CREMATORY: Woodfell Cemetery
24d. LOCATION (City, town, or county) (State): Harvard Latah Idaho

DATE REC'D BY LOCAL REG.: 12/10/69
REGISTRAR'S SIGNATURE: Maynel Kiskari
25. EMBALMER: E. Dete Albertson — LICENSE NO.: E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5314
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

RECEIVED NOV 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 3rd
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (In this place): abt 2 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial Hospital 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 711 Wyndemere

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Wallace	Theodore	McGill	11	14	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	9-20-1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): S.B.A. Appraiser 21
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Gooding, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fredrick McGill — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Sadie Schooler — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII 4
16. SOCIAL SECURITY NO.: 518-16-1244
17. INFORMANT'S OWN SIGNATURE: X Valetta A McGill — ADDRESS: Boise, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Brain Injury — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: Injuries to Chest & Abdomen — 1 hr

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Highway 93 Nr Leadore Lemhi 13300 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 14 1969 9:30 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Auto accident

22. I hereby certify that I attended the deceased from 10:30 A.M. 11-14, 1969, to 12:15 11-14, 1969, that I last saw the deceased alive on 11-14, 1969, and that death occurred at 12:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Salmon Ida	11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-19-69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 21st 1969	Viola E. Johnson	Delbert A. Jones	E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 26 1969

DEC 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5315
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED
DEC 11 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 45 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial Hosp. 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Frank
b. (Middle): "L"
c. (Last): Kerin

4. DATE OF DEATH (Month) (Day) (Year): Nov. 28, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 28, 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): operator Machine Shop 26
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Imperial, Penn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael Kerin — BIRTHPLACE: Austria
14. MOTHER'S MAIDEN NAME: Mary Smith — BIRTHPLACE: Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-14-0542
17. INFORMANT'S OWN SIGNATURE: Pearl Kerin — ADDRESS: Salmon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4274

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atrial fibrillation with decompensation — INTERVAL BETWEEN ONSET AND DEATH: 18 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-20, 1968, *to* 11-28, 1969, *that I last saw the deceased alive on* 11-28, 1969, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Roy Hindum 474 Tmd
23b. ADDRESS: Salmon Idaho
23c. DATE SIGNED: 12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Dec 8th 69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5316
Local Reg. No. 673
Reg. Dist. No. 430

RECEIVED DEC 4 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (in this place): 1959 110
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): BESSIE
b. (Middle): M.
c. (Last): LEE

4. DATE OF DEATH (Month) (Day) (Year): Nov. 26, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 15, 1881
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months 3, Days 11 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Colorado Springs, Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wesley Flowers — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Adalaid Obenchain — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 519-62-6873J1
17. INFORMANT'S OWN SIGNATURE: X Vernon M. Lee — ADDRESS: 205 South Laurel Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis & Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-26-59, 19__, *to* 11-26, 19 69, *that I last saw the deceased alive on* 11-26, 1969, *and that death occurred at* 11:50 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 386.
23b. ADDRESS: Box 68 Shoshone Idaho
23c. DATE SIGNED: 12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 12-2-1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser, Idaho

DATE REC'D BY LOCAL REG.: 12-3-69
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5317
Local Reg. No. 674
Reg. Dist. No. 430

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

DEC 4 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Center 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 541 Montana

3. NAME OF DECEASED (Type or Print)
a. (First): GIRLIE
b. (Middle): BELLE
c. (Last): TRIPP

4. DATE OF DEATH (Month) (Day) (Year): Nov. 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 20, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months 0, Days 8 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Hartville, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward Hickman — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Sarah — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-14-9368J1
17. INFORMANT'S OWN SIGNATURE: Geneva E Rapp — ADDRESS: Shoshone, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1980 Metastatic Ca of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24, 1969, *to* 11-28, 1969, *that I last saw the deceased alive on* 11-26, 1969, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 386
23b. ADDRESS: Box 68 Shoshone Idaho
23c. DATE SIGNED: 12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-1-1969
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 12-3-69
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5318
Local Reg. No. 68
Reg. Dist. No. 630

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN: Rexburg
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN: Rexburg
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): LOUISA
b. (Middle): CAROLINE
c. (Last): TEMPEST ANDERSON

4. DATE OF DEATH: November 1, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: January 1, 1870
9. AGE (In years last birthday): 99
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Nebraska City, Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Phineus Tempest
BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Sara Jane Wilson
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-60-6299
17. INFORMANT'S OWN SIGNATURE / ADDRESS: Lubie V. Anderson

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8877

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Neck of Left Femur — INTERVAL BETWEEN ONSET AND DEATH: 10-27-69

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fell at Nursing Home — 10-27-69
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 13
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 mm
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1943 *to* Nov. 1, 1969, *that I last saw the deceased alive on* Nov. 1, 1969, *and that death occurred at* 9:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: Nov. 3 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/4/69
24c. NAME OF CEMETERY OR CREMATORY: Rexburg
24d. LOCATION (City, town, or county) (State): Rexburg Madison Idaho

DATE REC'D BY LOCAL REG.: 11-4-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Kenneth Flamm
LICENSE NO.: E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 0 3 2010

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5319
Local Reg. No. 70
Reg. Dist. No. 630

BIRTH NO.

STATE OF IDAHO

RECEIVED NOV 17 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Madison 331

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg

c. LENGTH OF STAY IN THIS PLACE: Bureau of Vital Statistics

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Madison 331

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg

d. STREET ADDRESS (If rural, give location): North Center

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Nels	C.	Nelson	Nov. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Married	Sept. 6, 1880	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 28

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Smithfield, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nels Nelson — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Eliza Christensen — BIRTHPLACE: Brigham City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 518-07-7388

17. INFORMANT'S OWN SIGNATURE: Burton C. Nelson — ADDRESS: 123 N. Cent Rexburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio-sclerotic Cardio-vascular disease — 3 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Extreme Age -

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1965, *to* Nov 9, 1969, *that I last saw the deceased alive on* Nov 9, 1969, *and that death occurred at* 6:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Blaine H. Peacock MD	Rexburg, Idaho	11-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/12/69	Rexburg	Rexburg Madison Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-12-69	Leona Flamm	Leona Flamm	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5320
Local Reg. No. 69
Reg. Dist. No. 630

Certificate of Death

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 131 North Center

3. NAME OF DECEASED (Type or Print)
a. (First): ELLA
b. (Middle): WINNIFRED
c. (Last): KING REED

4. DATE OF DEATH (Month) (Day) (Year): November 13, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: September 6, 1888
9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Manchester, South Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William King
BIRTHPLACE: Wisconsin
14. MOTHER'S MAIDEN NAME: Jannette Adair
BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Jannette R. Fay
ADDRESS: Rigby, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Atrophic Gastritis — 1 year

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1969, *to* Nov 13, 1969, *that I last saw the deceased alive on* Nov. 13, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. F. Rigby MD. 442
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: Nov. 12 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 11/15/69
24c. NAME OF CEMETERY OR CREMATORY: Cedar Butte
24d. LOCATION (City, town, or county) (State): Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.: 11-13-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Kenneth Flamm
LICENSE NO.: E347

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5321
Local Reg. No. 78
Reg. Dist. No. 630

BIRTH NO.

RECEIVED DEC 18 1969 BUREAU OF VITAL STATISTICS

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Madison 331

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bureau of [illegible] COD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Maryland 21

b. COUNTY: 555

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ParkLand

d. STREET ADDRESS (If rural, give location): 18 Kentucky Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
TIMOTHY	FRANK	JENKINS	November 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Caucasion	Never Married	26 June 1949	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 05

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Winchester, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank James Jenkins — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Currently 7

16. SOCIAL SECURITY NO.: 8199

17. INFORMANT'S OWN SIGNATURE: Lt. R. D. Schomel Mc USNR — ADDRESS: Idaho Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crush injury to the Chest — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: n/a

19b. MAJOR FINDINGS OF OPERATION: n/a

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Automobile 06

21c. (CITY, TOWN, OR TOWNSHIP) 13330 (COUNTY) (STATE): ½ Mile No, Rexburg, Madison, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 16, 1969 2:15 A.M. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Auto Accident

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 Coroner 4 (Degree or title) Madison County

23b. ADDRESS: P.O.Box 13, Rexburg, Idaho

23c. DATE SIGNED: 17 November 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Nov. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

24d. LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: 11-19-69

REGISTRAR'S SIGNATURE: Leona Flamm

25. EMBALMER: [signature]

LICENSE NO.: E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 18 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5322
Local Reg. No. 79
Reg. Dist. No. 630

BIRTH NO.

RECEIVED DEC 1 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 133

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Madison 330
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Thornton
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Joseph	Andrew	Cherry	Nov.	22,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	18 July 1889	80	4	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ephriam, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Maroni Cherry	England	Lena Matie Christensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-22-8425
17. INFORMANT'S OWN SIGNATURE: Ed J. Cherry
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — several yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia — 1wk

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1969, *to* 11-22, 1969, *that I last saw the deceased alive on* 11-22, 1969, *and that death occurred at* 7P m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Peter J Petersen MD 413 (Degree or title)	Rexburg Idaho	11-25-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	25 Nov. 1969	Sutton Cemetery	Madison Co. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-8-69	Lona Flamm	Leo A Williams	E-319

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5323
Local Reg. No. 83
Reg. Dist. No. 450

BIRTH NO. 69-6194

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 4 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hosp. 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 410 East 5th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Antonia
b. (Middle):
c. (Last): Anguiano

4. DATE OF DEATH (Month) (Day) (Year): Nov. 4, 1969

5. SEX: female
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: June 21, 1969
9. AGE (In years last birthday): –
IF UNDER 1 YEAR: Months 4 Days 14
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rupert, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Igmacio Albarado, BIRTHPLACE: Cholula, Mexico
14. MOTHER'S MAIDEN NAME: Jannie Anguiano, BIRTHPLACE: Kingsville, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): – – –
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Omar Anguiano ADDRESS: 410 E. 5th Rupert Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

486X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 3, 1969, *to* Nov. 4, 1969, *that I last saw the deceased alive on* Nov. 4, 1969, *and that death occurred at* 5:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A C Truxal, M.D. 531
23b. ADDRESS: Rupert, Idaho
23c. DATE SIGNED: 11-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery,
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: 11-14-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Armand J Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5324
Local Reg. No. 84
Reg. Dist. No. 450

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 27 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 701 4th street

3. NAME OF DECEASED (Type or Print)
a. (First): Ernest
b. (Middle): Dennis
c. (Last): Jones

4. DATE OF DEATH (Month) (Day) (Year): Nov 5 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Apr 22 1883
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Willard Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Jones — BIRTHPLACE: Wales England
14. MOTHER'S MAIDEN NAME: Mary Ann Nichols — BIRTHPLACE: Willard Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 518-10-0159
17. INFORMANT'S OWN SIGNATURE: x Ross Owen Jones — ADDRESS: 1928 N.E. 91st Portland Ave

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): General debilities of advanced years — INTERVAL BETWEEN ONSET AND DEATH: many years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-27, 1959, *to* 11-5, 1969, *that I last saw the deceased alive on* 11-5-69, 19__, *and that death occurred at* 3:10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A F Dalley M D 127
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-8-69
24c. NAME OF CEMETERY OR CREMATORY: Almo Cemetery
24d. LOCATION (City, town, or county) (State): Almo Idaho

DATE REC'D BY LOCAL REG.: 11-14-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Robert C Walk — LICENSE NO. E294
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5325
Local Reg. No. 89
Reg. Dist. No. 40 d

Certificate of Death

STATE OF IDAHO

BIRTH NO. 69-11611

RECEIVED NOV 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paul Labor Camp
d. STREET ADDRESS (If rural, give location): R. 2, Rupert, Ida

3. NAME OF DECEASED (Type or Print)
a. (First): Baby Girl
b. (Middle): CONSTANTE
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): 11-6-69

5. SEX: Female
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Baby
8. DATE OF BIRTH: 11-6-69
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min. X

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Rupert, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Trinidad Constante
BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Stella Conde
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: --
17. INFORMANT'S OWN SIGNATURE: Minidoka Memorial Hospital Records
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Prematurity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): (5 months gestation).
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 Nov, 1969, *to* 6 Nov, 1969, *that I last saw the deceased alive on* 6 Nov, 1969, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H W Crawford 140 MD
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 18 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-13-69
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Ida

DATE REC'D BY LOCAL REG.: 11-20-69
REGISTRAR'S SIGNATURE: Mary Ellen Cashon
25. EMBALMER: Charles H. Persons
LICENSE NO.: E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5326
Local Reg. No. 85
Reg. Dist. No. 450

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (In hospital): ___
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walker Addn., So. F St 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 540
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): Walker Addn., So. F St.

3. NAME OF DECEASED (Type or Print)
a. (First): Olaf (Ole)
b. (Middle):
c. (Last): Anderson

4. DATE OF DEATH (Month) (Day) (Year): Nov. 8, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 16, 1880
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Amalgamated Sugar Co.
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hans Anderson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Anna Hanson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-09-3553
17. INFORMANT'S OWN SIGNATURE: Olaf O. Anderson — ADDRESS:

4/24

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Decompensated Cardiovascular disease and age — INTERVAL BETWEEN ONSET AND DEATH: Several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1967, *to* 8 Nov, 1969, *that I last saw the deceased alive on* 18 Mar, 1969, *and that death occurred at* 10:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H W Crawford 740 MD
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 14 Nov. 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-12-69
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Ida

DATE REC'D BY LOCAL REG.: 11-14-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Robert C Walk — LICENSE NO. E294
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 27 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 15 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5327
Local Reg. No. 2
Reg. Dist. No. 450

RECEIVED NOV 17 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka (340)
b. CITY OR TOWN: Rupert
c. LENGTH OF STAY (in this place): 40 years 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital (125)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka (340)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 906 B. Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	Onetia	Davis	Nov. 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	White	Married	June 11, 1891	78	4	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Black Fork, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benoni William Davis,	Iowa	Mary Matilda Person,	Brigham City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - - -	518-20-8207	x Emily Mary Davis	906 B. St Rupert Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A.S.C.V.D. — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 19 61, *to* Nov 8, 19 69, *that I last saw the deceased alive on* Nov 8, 19 69, *and that death occurred at* 9:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (253) (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ivan C. Humphreys M.D.	Rupert Idaho	10-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 10, 1969	Riverside Cemetery	Heyburn, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-14-69	Mary Ellen Carlson	Ormand Burch	E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 5328
Local Reg. No. 87
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 NOV 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF RESIDENCE (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1020-4th

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 1020-4th

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) F. c. (Last) Connervey

4. DATE OF DEATH (Month) (Day) (Year) Nov. 12, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Oct. 19, 1903

9. AGE (In years last birthday) 66
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Sheepherder

11. BIRTHPLACE (State or foreign country) Scottsbluff Nebr.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown Connervey
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME Mattie E. unknown
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) W.W. II 4369

16. SOCIAL SECURITY NO. 518-36-6599A

17. INFORMANT'S OWN SIGNATURE E J Predmore ADDRESS Rt 1 Rupert

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular Accident, due to Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Accessive alcohol consumption, — several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ☒ SUICIDE ☐ HOMICIDE ☐ (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1020 4th street home

21c. (CITY, TOWN, OR TOWNSHIP) Rupert (COUNTY) Minidoka (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 12 1969 *, to* Nov 12 1969 *, that I last saw the deceased alive on* D.O.A. *, 19 ___, and that death occurred at* 5 P.M. *, from the causes and on the date stated above.*

23a. SIGNATURE E.J. Predmore (Degree or title) M 332

23b. ADDRESS Rupert Idaho

23c. DATE SIGNED 11/14/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-15-69

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert, Ida

DATE REC'D BY LOCAL REG. 11-19-69

REGISTRAR'S SIGNATURE Mary Ellen Hanson

25. EMBALMER Robert Walk

LICENSE NO. E 294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5329
Local Reg. No. 86
Reg. Dist. No. 450

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Minidoka 340 — NOV 18 1969 — Bureau of Vital Statistics

b. CITY OR TOWN: Rupert

c. LENGTH OF STAY in this place: 2 wks

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: Minidoka 340

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert

d. STREET ADDRESS (If rural, give location): 524 So. "I" St., Rupert, Ida

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clyde	Theron	Grimes	Nov.	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 30, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Carpenter		unknown	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Grimes	unknown	Emily Adeline Davis	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
None	None	520-01-5908	x Josephine M. Grimes	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	C.V.A.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	A.S.C.V.D.	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* 11-13, 1969, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED (Month) (Day) (Year)
Leon K. Humphrey	263 MD	Rupert Idaho	11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. (City, town, or county) (State)
Burial	11-14-69	Rupert Cemetery	~~Denver, Colorado~~ Rupert Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-17-69	Mary Ellen Barbour	Robert E. Walk	E 294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5330
Local Reg. No. 92
Reg. Dist. No. 450

RECEIVED DEC 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
LENGTH OF STAY (in this place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert Idaho
d. STREET ADDRESS (If rural, give location) 109 2nd street

3. NAME OF DECEASED (Type or Print)
a. (First) Jesse
b. (Middle) Lee
c. (Last) Farris

4. DATE OF DEATH (Month) (Day) (Year) Nov 15 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Feb 15 1886

9. AGE (In years last birthday) 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired house painter

10b. KIND OF BUSINESS OR INDUSTRY 21

11. BIRTHPLACE (State or foreign country) Harrison Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas R Farris-Boliver
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Nancy Pearl Murphy-Pumpkin City, Ark.
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-18-6316

17. INFORMANT'S OWN SIGNATURE Wilma R. Farris
ADDRESS 109 2nd Rupert Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A & C V D. — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1958, *to* death, 19____, *that I last saw the deceased alive on* 11-14, 19 69, *and that death occurred at* 7:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE Jess K. Humphrey (Degree or title) 253 MD

23b. ADDRESS 645 5th St. - Rupert

23c. DATE SIGNED 11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov 18 1969

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) Rupert Idaho (State)

DATE REC'D BY LOCAL REG. 12-15-69

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Charles L Parsons
LICENSE NO. E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

APR 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5331
Local Reg. No. 88
Reg. Dist. No. 450

RECEIVED NOV 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-1200 north, 300 west
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rupert-1200 north, 300 west

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert Idaho
d. STREET ADDRESS (If rural, give location) Rural Route 5

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) W c. (Last) Livingston

4. DATE OF DEATH (Month) (Day) (Year) Nov 17 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Dec 5 1915
9. AGE (In years last birthday) 54 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Sheep Ranch
11. BIRTHPLACE (State or foreign country) Aberdeen Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Livingston-Randolph Utah BIRTHPLACE
14. MOTHER'S MAIDEN NAME Nancy Palmer Oxford Idaho BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-26-3540
17. INFORMANT'S OWN SIGNATURE & ADDRESS X Mrs Marie Myers 835 N Harrison Pocatello

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severely fractured skull and brain damage. — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) Hiway 24 06
21c. (CITY, TOWN, OR TOWNSHIP) 340 (COUNTY) (STATE) Rupert Minidoka County Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 17 1969 10 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Pick up truck ran off Hiway and turned over

22. *I hereby certify that I attended the deceased from* Did not see alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert L Walk (Degree or title) Coroner 583
23b. ADDRESS 710 6th street Rupert Idaho
23c. DATE SIGNED 11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov 19 1969
24c. NAME OF CEMETERY OR CREMATORY American Falls Cemetery
24d. LOCATION (City, town, or county) (State) American Falls Idaho

DATE REC'D BY LOCAL REG. 11-20-69
REGISTRAR'S SIGNATURE Mary Ellen Eaton
25. EMBALMER Charles D Parsons
LICENSE NO. E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5332
Local Reg. No. 90
Reg. Dist. No. 45-J

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (In this place) None
d. FULL NAME OF HOSPITAL OR INSTITUTION 303 N. Overland Ave. Hi-Way 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) # 27) R.F.D. # 3

3. NAME OF DECEASED (Type or Print) a. (First) Vicki b. (Middle) Leigh c. (Last) Brown

4. DATE OF DEATH (Month) Nov. (Day) 21, (Year) 1969

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH July 26, 1968

9. AGE (In years last birthday) 1 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ******* 62

10b. KIND OF BUSINESS OR INDUSTRY *******

11. BIRTHPLACE (State or foreign country) Burley, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE Max Wallace Brown - Burley, Idaho

14. MOTHER'S MAIDEN NAME BIRTHPLACE Karla Neiwert - Burley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Max W. Brown ADDRESS Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed Skull — INTERVAL BETWEEN ONSET AND DEATH: None

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto Accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) State Hiway 26

21c. (CITY, TOWN, OR TOWNSHIP) 13340 (COUNTY) Burley Minidoka (STATE) Idaho

21d. TIME OF INJURY (Month) Nov. (Day) 21, (Year) 1969 (Hour) 1:25 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Auto Accident

22. I hereby certify that I attended the deceased from Did Not See Alive, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____m., from the causes and on the date stated above.

23a. SIGNATURE Robert C Walk (Degree or title) Coroner

23b. ADDRESS 710-6th Rupert

23c. DATE SIGNED Nov 28-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 11/25/69

24c. NAME OF CEMETERY OR CREMATORY Pleasant View

24d. LOCATION (City, town or county) Burley, Idaho (State)

DATE REC'D BY LOCAL REG. 12-2-69

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER

LICENSE NO. E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5333
Local Reg. No. 91
Reg. Dist. No. 450

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 340 Minidoka DEC 5 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
c. LENGTH OF STAY (In this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION 912 West 100 South 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
d. STREET ADDRESS (If rural, give location) 912 West 100 South

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Hueston c. (Last) Duff
4. DATE OF DEATH (Month) Nov. (Day) 24, (Year) 1969
5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Aug. 1, 1900
9. AGE (In years last birthday) 69 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Rancher of
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Harwood, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Duff — BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Martha Jefferies — BIRTHPLACE Illinois
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-40-9670
17. INFORMANT'S OWN SIGNATURE Leonard Duff ADDRESS Paul, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 8-3-69.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary thrombosis 8--3-69.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3-69, 1969, to Nov. 24., 1969, that I last saw the deceased alive on 11-25, 1969, and that death occurred at ____ a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D.
23b. ADDRESS Burley
23c. DATE SIGNED 12-4-69.

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 28, 69
24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery
24d. LOCATION (City, town, or county) Paul, Idaho (State)

DATE REC'D BY LOCAL REG. 12-4-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 15 1999

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5334
Local Reg. No. 286
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

NOV 17 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY NezPerce 351
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home - 1503 - 9th Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE ~~XXXXXXX~~ Idaho
b. COUNTY NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1503 - 9th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Amos
b. (Middle) Clyde
c. (Last) Carpenter

4. DATE OF DEATH (Month) (Day) (Year) November 1, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 22 April 1888
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teamster 10
10b. KIND OF BUSINESS OR INDUSTRY Freight
11. BIRTHPLACE (State or foreign country) Genesee, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wesley Carpenter — BIRTHPLACE Tennessee
14. MOTHER'S MAIDEN NAME Effie Hopkins — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 22 6187
17. INFORMANT'S OWN SIGNATURE Annie Carpenter — ADDRESS Lewiston, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4360

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular Accident ~~[illegible]~~

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertension - 1960

DUE TO (c) Cerebro Vascular Accident 1960

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Senility · Arterio Sclerosis

INTERVAL BETWEEN ONSET AND DEATH: [illegible] 4-68

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/11 *19*49, *to* ~~[illegible]~~ Nov 1st, *19*69, *that I last saw the deceased alive on* March 4, *19*69, *and that death occurred at* 3 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Jacob E. Boedeker M.D. 022 (Degree or title)
23b. ADDRESS 1522 Beth St. Lewiston Idaho
23c. DATE SIGNED 11/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 5 Nov. 1969
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Gardens
24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 11-10-69
REGISTRAR'S SIGNATURE Glenara Walzen
25. EMBALMER W. E. Black
LICENSE NO. E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 12 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5335
Local Reg. No. 282
Reg. Dist. No. 220

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPHS HOSPITAL 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: WASHINGTON 48
b. COUNTY: ASOTIN 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CLARKSTON
d. STREET ADDRESS (If rural, give location): 1222 McCarroll

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HARVEY	JAMES	ASHCRAFT	Nov. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	March 2, 1906	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millworker 17	Lumber	Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eliza Ashcraft		Calep - Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	NONE	Sarah Ashcraft	1222 McCarrol Clarkston

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cancer of urinary bladder — INTERVAL BETWEEN ONSET AND DEATH: 1887 / > 6 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 1969	Infiltrating Grade III transitional cell CA	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1969, *to* Nov. 4, 1969, *that I last saw the deceased alive on* 11/4, 1969, *and that death occurred at* 11P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. F. Stack M.D.	307 Johnson Way Lewiston, Idaho	11/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 3	NOV. 6, 1969	Vineland Cemetery	Clarkston, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-10-69	Glenna Walzen	M Merchant	FD 5

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Merchant Funeral Home

DUTIES:

NOV 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 5 1987

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5336
Local Reg. No. 287
Reg. Dist. No. 220

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2yr-8mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 428 Bryden Drive

3. NAME OF DECEASED (Type or Print)
a. (First): BERTINA
b. (Middle): P.
c. (Last): SMYTH

4. DATE OF DEATH (Month) (Day) (Year): 5 November 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 28 Oct 1890
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Mandan, North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Nels Mickelson — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Olina Christina Seeverson — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 60 9516 JI
17. INFORMANT'S OWN SIGNATURE: Mrs June Corrin — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive heart failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic vascular disease (advanced)
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 3, 1969, *to* Nov. 5, 1969, *that I last saw the deceased alive on* Nov. 3, 1969, *and that death occurred at* 6 am *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O. V. Baumann M.D. 036
23b. ADDRESS: 626 5th Ave. Lewiston, Idaho
23c. DATE SIGNED: 11/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7 Nov. 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-10-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5337
Local Reg. No. 290
Reg. Dist. No. 220

BIRTH NO.

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 357
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 357
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 215-4th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thomas	Earl	McGill	Nov. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	June 26, 1885	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railroad 10	Railroad	Newton, Kansas	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
no record		no record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no record	A. Vassar	Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Above elbow amputation Rt

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-7, 1969, *to* 11-7, 1969, *that I last saw the deceased alive on* 11-7, 1969, *and that death occurred at* 8:34 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	307 St. John's Way-Lew	11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov. 10, 1969	Normal Hill	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-19-69	Glenard Walzer	Andrew A. Vassar	315

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

English

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

Amended April 2, 1970

State File No. 5338
Local Reg. No. 289
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 21 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Washington b. COUNTY: Asotin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 531 Blvd

3. NAME OF DECEASED (Type or Print): a. (First) Harold b. (Middle) c. (Last) Edgmand
4. DATE OF DEATH (Month) (Day) (Year): November 8, 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: October 2, 1896
9. AGE (In years last birthday): 73
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher
10b. KIND OF BUSINESS OR INDUSTRY: Cattle
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Edgmand BIRTHPLACE: Clio, Iowa
14. MOTHER'S MAIDEN NAME: Melissa Ewing BIRTHPLACE: Corieon, Iowa
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW I (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 537 34 1991
17. INFORMANT'S OWN SIGNATURE: Birdie B. Edgmand ADDRESS: Clarkston, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 13 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Gastro Intestinal hemorrhage (stress ulcer) — 10 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 31 October, 1969, *to* 8 Nov., 1969, *that I last saw the deceased alive on* 8 Nov., 1969, *and that death occurred at* 7 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: B. R. Stein, M.D. (Degree or title)
23b. ADDRESS: 307 St. Johns Way, Lewiston
23c. DATE SIGNED: 17 Nov 69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho
DATE REC'D BY LOCAL REG.: 11-19-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: V. Vassar
LICENSE NO.: E297

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
MAR 27 1970
Bureau of Vital Statistics

State of Washington
County of Asotin } ss.

Certificate No. 69-5338

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Harold Edgmand (Name on Original Certificate) who died (Was Born or Died) on Nov 8, 1969 (Date of Event)
in Lewiston, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	Oct 2, 1969	October 2, 1896

Subscribed and sworn to before me this 24th day of March, 19 70

Notary Public, residing at Clarkston

My commission expires May 2, 1970 (Seal)

Signed Birdie B Edgmand
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

531 Riverview Blvd, Clarkston, Wa 99403
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of WASHINGTON
County of Asotin } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 24th day of March, 19 70

Notary Public, residing at Clarkston

My commission expires May 2, 1970 (Seal)

Signed Michael R. Edgmand Birdie B Edgmand
(Signature of Any Credible Person)

841 W. Knapp, Stillwater, Okla 74074
(Street Address, City, State)

FORM DH 60-155

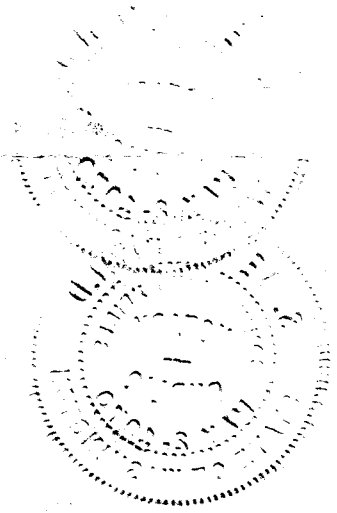

State File No. 5338
Local Reg. No. 289
Reg. Dist. No. 220

Certificate of Death

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 21 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Asotin 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 531 Blvd

3. NAME OF DECEASED (Type or Print)
a. (First): Harold
b. (Middle):
c. (Last): Edgmand

4. DATE OF DEATH (Month) (Day) (Year): Nov. 8, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct. 2, 1969
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: cattle
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Thomas Edgmand — BIRTHPLACE: Clio, Iowa
14. MOTHER'S MAIDEN NAME: Melissa Ewing — BIRTHPLACE: Corieon, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW I — (If yes, give war or dates of service): 3
16. SOCIAL SECURITY NO.: 537 34 1991
17. INFORMANT'S OWN SIGNATURE: Birdie B Edgmand — ADDRESS: Clarkston, Wash.

4319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 13 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: gastro Intestinal hemorrhage (stress ulcer) — 10 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 31 October 1969, *to* 8 Nov, 1969, *that I last saw the deceased alive on* 8 Nov, 1969, *and that death occurred at* 7 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B R Stern 496 MD
23b. ADDRESS: 307 St Johns Way Lewiston
23c. DATE SIGNED: 17 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-19-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 9 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 7 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 19 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

OCT 23 1970

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5339
Local Reg. No. 293
Reg. Dist. No. 220

BIRTH NO.

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this institution): 174
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchard Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 936- urrell

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alpha	C.	Nelson	Nov. 9 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 31 1882	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired 28		Sparta, N.C.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joshua Crouse	N.C.	Drucy Attwood	N.C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	51822-4834	X Mrs Daniel Nelson	Lewiston, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4/23, 19 57, *to* 11/9, 19 69, *that I last saw the deceased alive on* 11/29, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X R. O. Stover, M.D	939- Bryden Lewiston, Ida	11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 12, 1969	Normal Hill Cemetery	Lewiston, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-21-69	Glenara Dalzen	Andrew F. Vassar	E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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69-11628

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5340
Local Reg. No. 310
Reg. Dist. No. 220

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): St. Josephs Hospital

3. NAME OF DECEASED (Type or Print)
a. (First): Scott
b. (Middle): Benjamin
c. (Last): Gibbs

4. DATE OF DEATH (Month) (Day) (Year): November 11, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: November 9, 1969
9. AGE (In years last birthday): 0
IF UNDER 1 YEAR: Months 0, Days 2
IF UNDER 24 HRS.: Hours 4, Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 02
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Vern Gibbs
BIRTHPLACE: Spalding, Idaho
14. MOTHER'S MAIDEN NAME: Naomi Johnson
BIRTHPLACE: Lewiston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: Vern Gibbs
ADDRESS: 1494 Sycamore, Clarkston, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7769

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 40 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Premature
DUE TO (c): Premature Labor

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-9-69, 19__, *to* 11-11-69, 19__, *that I last saw the deceased alive on* 11-11-69, 19__, *and that death occurred at* 8:2 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 232
23b. ADDRESS: 347 St Johns Way Lewiston
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: November 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-12-69
REGISTRAR'S SIGNATURE: Glenora Walzen
25. EMBALMER: L.E. De Baun
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5341
Local Reg. No. 392
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2710 Clearwater Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 2710 Clearwater Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Eli E. Hollingsworth
b. (Middle):
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Nov. 11, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 4-1-1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: general
11. BIRTHPLACE (State or foreign country): Halltown, Missouri
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James R. Hollingsworth — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 712 09 5201
17. INFORMANT'S OWN SIGNATURE: Mary Hollingsworth — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shock Hemhorrage — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Gunshot Wpumb
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home 31
21c. (CITY, TOWN, OR TOWNSHIP) 1335 (COUNTY): Lewiston, Idaho NexPerce (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11 11 69 5:00PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Apparent Self inflicted

22. *I hereby certify that I attended the deceased from* 66 *19*, *to* ____, *19*____, *that I last saw the deceased alive on* ____, *19*____, *and that death occurred at* 5:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duclos 583 (Degree or title): coroner 4
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 11/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 14, 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memorial
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-21-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

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NOV 25 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 24 1969 Bureau of Vital Statistics

State File No. 5342
Local Reg. No. 288
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Lewiston
LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 303 2nd Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 303-2nd Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Chester b. (Middle) Eastman c. (Last) Dickinson

4. DATE OF DEATH (Month) (Day) (Year): Nov. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	July 11, 1878	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Conductor	railroad	Amherst, Mass.	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
E. N. Dickinson	Mass.	Sarah Pease	Conn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
none		701 12 3775	x Mary Dickinson Rosenthal	Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile osteoporosis - Pulmonary fibrosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 19, 1967, *to* Nov 12, 1969, *that I last saw the deceased alive on* Nov 12, 1969, *and that death occurred at* 7:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward C. Robinson 232	347 St Johns Way Lewiston Ida	11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal	Nov. 13, 1969	Havre, Montana	Havre Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-13-69	Glenna Dalzell	Andrew F. Vassar	E315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: FEB 26 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-11629 RECEIVED

Certificate of Death

STATE OF IDAHO

DEC 3 1969

Bureau of Vital Statistics

State File No. 5343
Local Reg. No. 997
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NezPerce 35
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY in this place 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Josephs 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) St. Josephs Hospital

3. NAME OF DECEASED (Type or Print)
a. (First) Billy
b. (Middle) Daniel
c. (Last) Henry Jr.

4. DATE OF DEATH (Month) (Day) (Year) November 12, 1969

5. SEX Male

6. COLOR OR RACE Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH November 10, 1969

9. AGE (In years last birthday) 0
IF UNDER 1 YEAR: Months 0 Days 1
IF UNDER 24 HRS.: Hours 4 Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 52

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Lewiston, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Billy Daniel Henry
BIRTHPLACE Lewiston, Idaho

14. MOTHER'S MAIDEN NAME Donna Jean Mathews
BIRTHPLACE Nespelem, Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE X Billy D. Henry
ADDRESS 905 - Preston Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cause not determined 7969
INTERVAL BETWEEN ONSET AND DEATH 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION No Cause found at autopsy.

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/10, 1969, *to* 11/12, 1969, *that I last saw the deceased alive on* 11/12, 1969, *and that death occurred at* 6:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE W Peirce 420 (Degree or title) MD

23b. ADDRESS Lewiston Ida

23c. DATE SIGNED 11/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 15 Nov 1969

24c. NAME OF CEMETERY OR CREMATORY Sweetwater Cemetery

24d. LOCATION (City, town, or county) (State) Sweetwater, Idaho

DATE REC'D BY LOCAL REG. 11-25-69

REGISTRAR'S SIGNATURE Elmara Walzen

25. EMBALMER K. H. Malcom K.H. Malcom

LICENSE NO. E-376

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 3 0 2009

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5344
Local Reg. No. 328
Reg. Dist. No. 220

RECEIVED DEC 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NezPerce 35
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 1week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 624-24th St North

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) V. c. (Last) Chaffins

4. DATE OF DEATH (Month) (Day) (Year) Nov. 17, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 16, 1931
9. AGE (In years last birthday) 38 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.F.I. 10
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boise, Idaho.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME V.W. Chaffins BIRTHPLACE S.D.
14. MOTHER'S MAIDEN NAME Myrtle Guay BIRTHPLACE Ocan, Wis.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-30-4664
17. INFORMANT'S OWN SIGNATURE A. Myrtle Chaffins ADDRESS Lewiston, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia Cerea - — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) chronic glomerular Nephritis — 3 yrs
DUE TO (c) Hypertensive Ht disease — 3 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

403X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? No Injury -

22. *I hereby certify that I attended the deceased from* ____, 19__, to Nov 17, 1969, *that I last saw the deceased alive on* Nov 17, 1969, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Frank L Baldwin MD
23b. ADDRESS 1522-17th St Lewiston Idaho
23c. DATE SIGNED 12/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 20, 1969
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE Glenora Dalzen
25. EMBALMER Andrew F Vassar
LICENSE NO. E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 25 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5345
Local Reg. No. 295
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1102-12th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Joseph
b. (Middle): W
c. (Last): Thometz

4. DATE OF DEATH (Month) (Day) (Year): Nov. 17, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 16, 1887
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): agent 24
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Stanbury, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Anthony Thometz — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 44 3466A
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH 4309
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hyperthyroidism

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1958, *to* Nov. 11, 1969, *that I last saw the deceased alive on* Nov. 17, 1969, *and that death occurred at* 11:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 160 (Degree or title)
23b. ADDRESS: 307 St. John's Way, Lewiston, Idaho
23c. DATE SIGNED: 11-21-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Nov. 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Malad, Idaho
24d. LOCATION (City, town, or county) (State): Malad, Idaho

DATE REC'D BY LOCAL REG.: 11-26-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

English

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5346
Local Reg. No. 294
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce (351) DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (at this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp. (128)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater (180)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Wilma
b. (Middle): Fern
c. (Last): Cory

4. DATE OF DEATH (Month) (Day) (Year): Nov. 19, 1969

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Mar. 14, 1909

9. AGE (In years last birthday): 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): book keeper (08)

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Forest Ser.

11. BIRTHPLACE (State or foreign country): Peola, Ind.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur A. Hall
BIRTHPLACE: Unk.

14. MOTHER'S MAIDEN NAME: Unk.
BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 401-28-6081

17. INFORMANT'S OWN SIGNATURE: L
ADDRESS: Orofino

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Cellulitis Ancma (2000)
INTERVAL BETWEEN ONSET AND DEATH: 2 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-18-69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11/15, 19[illegible], *to* 11-19, 19[illegible], *that I last saw the deceased alive on* [illegible], 19[illegible], *and that death occurred at* 7:10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] M.D.
23b. ADDRESS: Lewiston Idaho 307 [illegible]
23c. DATE SIGNED: 11/21/69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal (3)
24b. DATE: Nov. 21, 69
24c. NAME OF CEMETERY OR CREMATORY: Ellis Funeral Home
24d. LOCATION (City, town, or county) (State): Paoli, Orange, Ind.

DATE REC'D BY LOCAL REG.: 11-26-69
REGISTRAR'S SIGNATURE: Glenora Walzer
25. EMBALMER: [illegible]
LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 30 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 22 1977

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5347
Local Reg. No. 246
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1427 - 9th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) ALBION
c. (Last) PLATT

4. DATE OF DEATH (Month) (Day) (Year) 23 Nov 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 5 April 1877
9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Cattle/Sheep
11. BIRTHPLACE (State or foreign country) Iowa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas E. Platt — BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Carrie Harris — BIRTHPLACE Mineral Pt., Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 54 0614JI
17. INFORMANT'S OWN SIGNATURE × Kenneth B. Platt — ADDRESS Lewiston, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2509 ~~Hy~~ Acute Avascular Gravitation — INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis Hypertensive Ht disease yrs
DUE TO (c) Diabetes Mellitus 30 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility Age 94 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960 *to* Nov 23, 1969, *that I last saw the deceased alive on* Nov 23, 1969, *and that death occurred at* 9:30 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 022 Joseph E Beeder M.D.
23b. ADDRESS 1522 17th St Lewiston Idaho
23c. DATE SIGNED 11/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 30
24b. DATE 28 Nov 1969
24c. NAME OF CEMETERY OR CREMATORY Genesee City Cemetery
24d. LOCATION (City, town, or county) (State) Genesee, Idaho

DATE REC'D BY LOCAL REG. 11-25-69
REGISTRAR'S SIGNATURE Glenara Walzen
25. EMBALMER W E Black — LICENSE NO. E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 17 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 05 1995

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5348
Local Reg. No. 302
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

DEC 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
c. LENGTH OF STAY (In this place): 9 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 627 Warner Avenue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
d. STREET ADDRESS (If rural, give location): 617 Warner Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Arvid
b. (Middle):
c. (Last): Anderson

4. DATE OF DEATH (Month) (Day) (Year): November 25, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan 12, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY: self
11. BIRTHPLACE (State or foreign country): Vannas, Sweden
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Carl O. Anderson — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Marie Anderson — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 330-20-6592
17. INFORMANT'S OWN SIGNATURE: Mrs. Edith Anderson — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma prostate gland — INTERVAL BETWEEN ONSET AND DEATH: 75 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1965
19b. MAJOR FINDINGS OF OPERATION: CA prostate
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1968, *to* Nov 25, 1969, *that I last saw the deceased alive on* Oct 28, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: R. F. Black M. D. 492 (Degree or title)
23b. ADDRESS: 307 St John Way Lewiston
23c. DATE SIGNED: 12/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial removal 3
24b. DATE: Nov. 29, 1969
24c. NAME OF CEMETERY OR CREMATORY: Spokane Memorial Gardens
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 12-29-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: V. Visser
LICENSE NO.: E293

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hazen & Jaeger Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5349
Local Reg. No. 300
Reg. Dist. No. 220

Certificate of Death

RECEIVED
DEC 3 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 240 - 6th Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 240 - 6th Street

3. NAME OF DECEASED (Type or Print)
a. (First): RUSSELL
b. (Middle): FURNISH
c. (Last): McRAE

4. DATE OF DEATH (Month) (Day) (Year): 27 November 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 16 Feb 1911
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Edgerman, Lumber Mill 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumbering
11. BIRTHPLACE (State or foreign country): Shelbina, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. McRae — BIRTHPLACE: Marion Co., Mo.
14. MOTHER'S MAIDEN NAME: Annie Gunby — BIRTHPLACE: Lentner, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 01 9161
17. INFORMANT'S OWN SIGNATURE: Lloyd McRae — ADDRESS: Winchester, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: monents

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 3 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* - - - - - - 19 - -, *to* - - - - - - 19 - -, *that I last saw the deceased alive on* - - - - - - 19 - -, *and that death occurred at* 5:25 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duclos — 533 4 (Degree or title): NezPerce Co. Coroner
23b. ADDRESS: 419 Stewart Ave. Lewiston, Idaho
23c. DATE SIGNED: 1 Dec 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1 Dec. 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-1-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W. E. Black — W E Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5350
Local Reg. No. 298
Reg. Dist. No. 220

BIRTH NO.

RECEIVED DEC 3 1969 Bureau of Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give NAME OF TOWNSHIP (In this place)): LEWISTON
c. [illegible]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GARDEN CITY APTS. # 207

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: NEZ PERCE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
d. STREET ADDRESS (If rural, give location): GARDEN CITY APTS.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WALLACE	(NMI)	O'KEEFE	11	27	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Sept, 23, 1894	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner	Uranium Mines	Asotin, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jack O'Keefe	Unknown	Mary Etta	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	541-20-2090	Edna O'Keefe	Garden City Apts. Lew. Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Disease
DUE TO (c) Deafness

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 1968, *to* Nov 27, 1969, *that I last saw the deceased alive on* Nov 26, 1969, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. V. Bauman, M.D. 036	C. V. Bauman, M. D. 626 5th Ave. Lewiston Idaho	11-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
CREMATION	Nov. 29, 1969	Mazen-Jaeger Cremetory	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-28-69	Minard Dalzen	W C Merchant	FD 5

FIRM NAME: Merchant Funeral Home Clarkston, Wn

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

DR - W. H. Bond

State File No. 5351
Local Reg. No. 303
Reg. Dist. No. 220

Certificate of Death

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPHS HOSPITAL 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: NEZ PERCE 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
d. STREET ADDRESS (If rural, give location): 716 10th St.

3. NAME OF DECEASED (Type or Print)
a. (First): MICHAEL
b. (Middle): (NMI) POOLEY
c. (Last):

4. DATE OF DEATH (Month) 11 (Day) 27 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Nov. 27, 1969
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 1 / Min. 32

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE 02
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Mike Pooley — BIRTHPLACE: UNKNOWN
14. MOTHER'S MAIDEN NAME: Margaret Jean Tucker — BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S OWN SIGNATURE: Mike Pooley — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7701

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Prematurity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Premature Separation Placenta
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/27, 1969, *to* 11/27, 1969, *that I last saw the deceased alive on* 11/27, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. H. Bond 051
23b. ADDRESS: 152217th St
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: December 1, 1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 12-3-69
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: R. Merchant
LICENSE NO.: FD 5

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Merchant Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5352
Local Reg. No. 309
Reg. Dist. No. 220

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 831 Linden Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	EVA	AGNES	SNYDER	27 Novmeber 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	14 June 1920	49				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Potlatch, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Bryon VanIdour	no record	Claira Maxey	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	None	Eldora Snyder	Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) IDIOPathic MyocarDiopathy — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 1959 *to* 27 Nov, 1969, *that I last saw the deceased alive on* 11-16, 1969, *and that death occurred at* 8:15 PM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	317 [illegible] Wash	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal/Burial	1 Dec 1969	Moscow City Cemetery	Moscow, Latah Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-12-69	Glenora Walgen	W E Black	E-426

FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5353
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

NOV 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Owyhee 370	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Wilder
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homedale Nursing Home 305	d. STREET ADDRESS (If rural, give location) Rt. # 1

3. NAME OF DECEASED (Type or Print) a. (First) Ellis	b. (Middle)	c. (Last) Connell	4. DATE OF DEATH (Month) 11	(Day) 5	(Year) 69	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 18, 1894	9. AGE (In years last birthday) 75	IF UNDER 1 YR. Months 7 Days 1	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Albe, Oregon		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Helem Connell	BIRTHPLACE UNK		14. MOTHER'S MAIDEN NAME Carrie Ellis		BIRTHPLACE UNK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-58-9671		17. INFORMANT'S OWN SIGNATURE Howard B Connell		ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Occlusion	Armed
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pulmonary Emphysema	Years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 15, 1969, *to* Nov 5, 1969, *that I last saw the deceased alive on* Nov 5, 1969, *and that death occurred at* 3 p *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 570 (Degree or title)	23b. ADDRESS Caldwell Ida	23c. DATE SIGNED 11-17-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE Nov. 10, 1969	24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery	24d. LOCATION (City, town, or county) (State) Caldwell, Idaho
DATE REC'D BY LOCAL REG. Nov. 20 69	REGISTRAR'S SIGNATURE Andrew Warfield	25. EMBALMER Rodney W. Dakan	LICENSE NO. E-505

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Dakan Funeral Chapel, Cald, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5354
Local Reg. No. 392
Reg. Dist. No.

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 10 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Murphy
c. LENGTH OF [illegible]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Murphy Flats 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Murphy
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): M.
c. (Last): McNamara

4. DATE OF DEATH (Month) (Day) (Year): Nov. 5, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): NeverMarried
8. DATE OF BIRTH: Feb. 23, 1895
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Anamosa, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward McNamara — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Ella McGirl — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI 3
16. SOCIAL SECURITY NO.: 482-42-9452
17. INFORMANT'S OWN SIGNATURE — ADDRESS: McNamara Funeral Home Anamosa, Iowa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7963

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Natural Causes — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I ~~attended the deceased from~~ investigated only, 19__, to Nov. 5, 1969, that I ~~last saw the~~ did not see deceased alive on Nov 5, 1969, and that death occurred at 12:15 P m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Andrew Warfield - Coroner 553
23b. ADDRESS: Homedale, Idaho
23c. DATE SIGNED: Nov. 7 '69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Nov. 10, 1969
24c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
24d. LOCATION (City, town, or county) (State): Anamosa, Iowa

DATE REC'D BY LOCAL REG.: Nov. 6, 1969
REGISTRAR'S SIGNATURE: Andrew Warfield
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 18 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 4 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5355
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Owyhee 370 — NOV 17 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): City

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Milton	R. (Bob)	Petersen	Nov. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Feb. 20, 1948	21				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Service Station 06	Co-op Oil Co.	Gregory, South Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marvin A. Petersen	Spencer, Neb.	Leona Sprenkle	Brooksburg, Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Viet Nam 7	518-58-6501	x Marvin A. Petersen	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken Neck — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Concussion of Skull
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Highway 95 in City	Homedale	Owyhee	Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21f. HOW DID INJURY OCCUR?
Nov. 9 '69 11:50 P.M.		Auto Accident - 1 Car rolled over

22. *I hereby certify that I attended the deceased from* investigated only *to* — *to* Nov. 9, 1969, *that I last saw* did not see *the deceased alive on* Nov. 9, 1969, *and that death occurred at* 11:50 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Andrew Warfield	583 - Coroner	Homedale, Idaho	Nov. 13 '69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-13-1969	Marsing - Homedale	Homedale, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 13 '69	Andrew Warfield	Thomas C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 1 1 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED NOV 24 1969 Bureau of Vital Statistics

State File No. 5356
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. # 1 662

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing
d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Parley		Larsen	Nov. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Mar. 22, 1909	60	7 / 18	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Ashton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nels Larsen	Star Valley Ida.	Anne C Christensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		519-43-6268	Darell Larsen	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchogenic Ca — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-23-69	Bronchogenic Ca of Rt. main stem Bronchus	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-22, 19 69, *to* 11-10-69, 19, *that I last saw the deceased alive on* 10-23-69, 19, *and that death occurred at* @ 3:00 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John E. Nielsen M.D. 389	303 E. Logan	11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 13, 69	Hillcrest Mem. Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-1969	Andrew Warfield	Rodney W Dakan	E-508

FIRM NAME: Dakan Funeral Chapel, Cald., Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 2 6 1969

DEC 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5357
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

RECEIVED NOV 24 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homedale Nursing Home 305

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print): a. (First) Maggie b. (Middle) Johnny c. (Last)

4. DATE OF DEATH (Month) (Day) (Year): Nov. 14, 1969

5. SEX: Female

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 1, 1865

9. AGE (In years last birthday): 104 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-60-8993

17. INFORMANT'S OWN SIGNATURE x Hubert Bacon — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4123 Arteriosclerotic Heart dis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death Diabetis Mellitus — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1960, *to* Nov 14, 1969, *that I last saw the deceased alive on* Nov 14, 1969, *and that death occurred at* 4 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 370 MD (Degree or title)

23b. ADDRESS Caldwell Ida

23c. DATE SIGNED: 11-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 17, 1969

24c. NAME OF CEMETERY OR CREMATORY: Duck Valley Indian Res.

24d. LOCATION (City, town, or county) (State): Owyhee, Nevada

DATE REC'D BY LOCAL REG.: Nov. 20 1969

REGISTRAR'S SIGNATURE: Andrew Warfield

25. EMBALMER: Howard C. Flahiff

LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5358
Local Reg. No. 393
Reg. Dist. No.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homedale Nursing Home 365

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print)
a. (First): Arthur
b. (Middle):
c. (Last): Hansen

4. DATE OF DEATH: Nov. 19, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: April 20, 1898

9. AGE (In years last birthday): 71
IF UNDER 1 YEAR — Months: 6 Days: 29
IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Hansen
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Sena Jensen
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 530-01-3015

17. INFORMANT'S OWN SIGNATURE: Virginia B. Hansen
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Minutes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 1, 1969, *to* Nov 19, 1969, *that I last saw the deceased alive on* Nov 19, 1969, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Emmett Ida
23c. DATE SIGNED: 11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 11-22-1969
24c. NAME OF CEMETERY OR CREMATORY: Carlin Cemetery
24d. LOCATION (City, town, or county) (State): Carlin, Nevada

DATE REC'D BY LOCAL REG.: 11-21-69
REGISTRAR'S SIGNATURE: Andrew Kirkfield
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-491
FIRM NAME: Homedale's Flahiff Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5359
Local Reg. No. 392
Reg. Dist. No.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics
STATE OF IDAHO

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Owyhee 37c
b. CITY OR TOWN: Homedale
c. LENGTH OF STAY IN this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION: Juniper Mountain

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 37c
c. CITY OR TOWN: Homedale
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Norman	Edgar	Taylor	Nov.	20,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Jan. 4, 1947	22				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Nampa, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William R. Taylor	Kansas	Gladys Churchill	Melba, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-54-8383	x Gladys M. Taylor	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Skull fragmentation-left — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gun Shot wound-30.30 rifle
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov. 21, 69	Massive Skull fracture - left side of face and head	YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Juniper Mountain 31	Homedale 13570 Owyhee Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Nov. 20, 1969 7:50P		Gun went off & struck in Chin left side of face did not die

22. *I hereby certify that I ~~attended the deceased from~~ investigation only, 19 to Nov. 21, 1969, that I ~~last saw the~~ deceased alive on Nov. 21, 1969, and that death occurred at 7:50P.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Andrew Warfield - Coroner	Homedale, Idaho	Nov. 21, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 25, 1969	Marsing-Homedale Cemetery	Marsing Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21 1969	Andrew Warfield	Leonard C. Flahiff	E-481

FIRM NAME: Homedale's Flahiff Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended 10-27-82

Certificate of Death

STATE OF IDAHO

State File No. 5360
Local Reg. No. 152
Reg. Dist. No. 330

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Payette 380 — NOV 12 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Fruitland — LENGTH OF STAY (in this place): Transit
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Interstate 80, 2 miles East of Palisades Junction

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 83651
d. STREET ADDRESS (If rural, give location): 1608 1st. Street. South

3. NAME OF DECEASED (Type or Print): a. (First) Louis — b. (Middle) — c. (Last) Bauer

4. DATE OF DEATH (Month) (Day) (Year): November 2, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: March 5, 1921

9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Ovid, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Conrad Bauer — BIRTHPLACE: Frank, Russia

14. MOTHER'S MAIDEN NAME: Marie Ginter — BIRTHPLACE: Frank, Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 519 32 7802

17. INFORMANT'S OWN SIGNATURE: Louis Bauer — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Traumatic Head and Chest Injuries — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Fruitland 13580 Payette Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 2, 1969 Unk. A.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: One Car Accident on Interstate 80

22. *I hereby certify that I ~~attended the deceased from~~ Investigated, to ~~xxxxxxxxxx 19xxx, that I last saw~~ the deceased alive on* Nov. 2, *19 69, and that death occurred at* Unk. A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Hardy Harkson 583 — (Degree or title): Coroner

23b. ADDRESS: Payette, Idaho

23c. DATE SIGNED: 11-4-1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-5-69

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-7-69

REGISTRAR'S SIGNATURE: Kenneth Anderson

25. EMBALMER: Keith M. Johnson — LICENSE NO.: E-517

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 14 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 17 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics, Standards, and Local Health Services

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

RECEIVED
BUREAU OF
VITAL STATISTICS
OCT 27 12 44 PM '82

State of _____ } ss.
County of _____

Certificate No. 69-5360
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of death

for Louis Bauer (Name on Original Certificate) who died (Was Born, Died, etc.) on November 2, 1969 (Date of Event)
in Payette County (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
Item 13 Father's birthplace	Saratoff, Germany	Frank Russia
Item 14 Mother's birthplace	Saratoff, Germany	Frank Russia

Subscribed and sworn to before me this 27th day of October, 1982.
Notary Public, Thomas Cartright
Residing at Boise
My commission expires 4-20-1986
(Seal)

Marguerite Robinett
Signature of Applicant
135 Mellon Ave Nampa Idaho
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ } ss.
County of _____

(Must be completed ___)
(Is not necessary ___)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, 19___.
Notary Public, _____
Residing at _____
My commission expires _____
(Seal)

_____
Supporting Signature

_____
Street Address, City, State

Record of Funeral issued April 9, 1951, gives birthplace of deceased, Conrad Bauer, as Frank Russia Mother's birth place is Frank, Russia. Information given to F. H.
Vital Statistics

OCT 27 1982

Certificate of death for father shows birth place for Conrad Bauer, as Frank, Russia. Father, Conrad died April 8, 1951. State File # 51-1286
Viewed by V.S.

State File No. 5361
Local Reg. No. 153
Reg. Dist. No. 330

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Fruitland
c. LENGTH OF STAY (In this place): Moments
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Interstate #80 2 Mi. E. of Palisade Junct. 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
d. STREET ADDRESS (If rural, give location): U.S. Motel, Apt. #4

3. NAME OF DECEASED (Type or Print)
a. (First): Lorraine
b. (Middle): Edna
c. (Last): BOTONIS

4. DATE OF DEATH (Month) (Day) (Year): November 2, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: February 21, 1929
9. AGE (In years last birthday): 40 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk 25
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Los Angeles, California
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Rolla Rhodes — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Estha Whitehead — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): — —
16. SOCIAL SECURITY NO.: 564-34-9218
17. INFORMANT'S OWN SIGNATURE: Estha Tooley — ADDRESS: Parma, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Traumatic Chest Injuries — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Fruitland 13380 Payette Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 2, 1969 Unk. A. m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? One Car Accident on Interstate 80.

22. *I hereby certify that I ~~attended the deceased from~~ Investigated ~~19~~ ~~to~~ ~~19~~ ~~that I last saw the deceased alive on~~ ~~19~~ and that death occurred at Unk. A m., from the causes and on the date stated above.*

23a. SIGNATURE: Hardy H Larkson 583 — (Degree or title): Coroner 4
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 11-4-1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 11-5-1969
24c. NAME OF CEMETERY OR CREMATORY: Roswell Cemetery
24d. LOCATION (City, town, or county) (State): Roswell, Canyon Cy, Idaho

DATE REC'D BY LOCAL REG.: 11-7-69
REGISTRAR'S SIGNATURE: Ashrabel Anderson
25. EMBALMER: Keith M. Jensen — LICENSE NO. E-511

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 30 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 2 1982

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5362
Local Reg. No. 151
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380 — NOV 12 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY in this place: 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 353

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1023 1st. Ave. North

3. NAME OF DECEASED (Type or Print): a. (First) Ray — b. (Middle) Ernest — c. (Last) REED

4. DATE OF DEATH (Month) (Day) (Year): November 3, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: February 18, 1889

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Boone County, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ira A. Reed — BIRTHPLACE: Pennsylvania

14. MOTHER'S MAIDEN NAME: Sarah C. Dailey — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-44-8058

17. INFORMANT'S OWN SIGNATURE: Thomas A. Reed — ADDRESS: Payette, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Cerebral vascular accident and left hemiplegia — 28 days

DUE TO (c): Generalized arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Nov. 3, 69

22. *I hereby certify that I attended the deceased from* 10-6-69, 19____, *to* 10-7-69, 19____, *that I last saw the deceased alive on* 11-3-69, 19____, *and that death occurred at* 6:15P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. — **23b. ADDRESS**: Payette, Idaho — **23c. DATE SIGNED**: 11-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 11-6-1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Rosedale — **24d. LOCATION** (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: 11-7-69 — REGISTRAR'S SIGNATURE: Edward Anderson

25. EMBALMER: Keith M. Jensen — LICENSE NO.: E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5363
Local Reg. No. 154
Reg. Dist. No. 330

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 380
a. COUNTY: Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 17Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cornor 1st Ave.S. 9th Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 2022 1st Ave N.

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): William
c. (Last): Walker

4. DATE OF DEATH (Month) (Day) (Year): Nov 5 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 10 1910
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Packing Shed 06
10b. KIND OF BUSINESS OR INDUSTRY: Produce
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Russell Walker — BIRTHPLACE: Tennessee
14. MOTHER'S MAIDEN NAME: Clara Hook — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 491-12-3728
17. INFORMANT'S OWN SIGNATURE: Mrs Lucy Walker — ADDRESS: Payette Ida

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*	(a) Myocardial infarction	10 min.
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*	DUE TO (b) Coronary thrombosis	10 min.
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Skin cancer of face	10 years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 10, 1961, *to* Nov. 5, 1969, *that I last saw the deceased alive on* Oct. 27, 1969, *and that death occurred at* 3:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE 082 (Degree or title): E. G. Carroll, M.D.
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 11/6/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-8-69
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: 11-10-69
REGISTRAR'S SIGNATURE: Annabel Anderson
25. EMBALMER: Donald F Brown
LICENSE NO.: E-408

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Chapel of the Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 27 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5364
Local Reg. No. 155
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 14 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
d. STREET ADDRESS (If rural, give location): 419 Kansas Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Clara
b. (Middle): Emma
c. (Last): ALCOCK

4. DATE OF DEATH (Month) (Day) (Year): November 8, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 17, 1892
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: August Meyer — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Sybilla Stahlman — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): — —
16. SOCIAL SECURITY NO.: 548-36-4795 B
17. INFORMANT'S OWN SIGNATURE: C. W. Alcock — ADDRESS: Fruitland, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): ASHD and congestive failure — INTERVAL BETWEEN ONSET AND DEATH: years and 5 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): CVA and left hemiplegia — 19 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-20-69, 19__, *to* 11-8-69, 19__, *that I last saw the deceased alive on* 11-7-69, 19__, *and that death occurred at* 11:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 574 (41)
23b. ADDRESS: Payette, Ida.
23c. DATE SIGNED: 11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-11-1969
24c. NAME OF CEMETERY OR CREMATORY: Park View Cemetery
24d. LOCATION (City, town, or county) (State): New Plymouth Idaho

DATE REC'D BY LOCAL REG.: 11-12-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Keith M. Jensen — LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 20 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5365
Local Reg. No. 156
Reg. Dist. No. 330

RECEIVED DEC 4 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
LENGTH OF STAY (in this place) 1½ Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location) 819 Plymouth Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Blanche b. (Middle) Laura c. (Last) MOORE

4. DATE OF DEATH (Month) (Day) (Year) November 27, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH December 20, 1871

9. AGE (In years last birthday) 97
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Lafayette, Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Damrow
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Catherine Geyer
BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) — —

16. SOCIAL SECURITY NO. 518-54-6875J1

17. INFORMANT'S OWN SIGNATURE Grace L. Benjamin
ADDRESS New Plymouth, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4337

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral arteriosclerotic thrombosis and diabetes — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis and senility — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. chronic arteriosclerotic heart disease with decompensation — 5 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 6, 1969, *to* Nov. 27, 1969, *that I last saw the deceased alive on* Nov. 27, 1969, *and that death occurred at* 6:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Geo. E. Davis, M.D. (Degree or title)

23b. ADDRESS New Plymouth, Idaho

23c. DATE SIGNED Nov. 29, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial

24b. DATE Dec. 2, 1969

24c. NAME OF CEMETERY OR CREMATORY Silver Creek Cemetery

24d. LOCATION (City, town, or county) Silver Creek (State) Nebraska

DATE REC'D BY LOCAL REG. 12-1-69

REGISTRAR'S SIGNATURE

25. EMBALMER Ruth M. Jensen
LICENSE NO. E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 20 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5366
Local Reg. No. 157
Reg. Dist. No. 330

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 38 Payette
DEC 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitland
c. LENGTH OF STAY (In this place) 20 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION 304 2nd St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Ida ho
b. COUNTY Payette 38
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitland
d. STREET ADDRESS (If rural, give location) 304 2nd St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Dowling	Smith	Nov. 28 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct 9 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Minnor 07	Minning	Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Steven Smith	Iowa	May H. Dowling	Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War 13	518-09-2405A	Ida May Smith	Fruitland Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1890

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Sarcoma of the Kidney — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov 18, 1969	Metastatic Sarcoma of the kidney	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 17, 1969, *to* Nov 28, 1969, *that I last saw the deceased alive on* Nov 25, 1969, *and that death occurred at* 8:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lester Hunt	M.D.	195 SW 2nd Ave Ontario, Oregon	28 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
3 Removal Burial	Dec 1 1969	St Johns	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-2-69		Donald F Brown	E-408

FIRM NAME: Ontario Chapel of the Roses

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 4 1969

JAN 9 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 5367
Local Reg. No. 19
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Power 390
NOV 14 1969
b. CITY OR TOWN Rockland
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rockland
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) LEONIDUS
b. (Middle)
c. (Last) RALPHS

4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1969

5. SEX Male

6. COLOR OR RACE Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept. 17, 1886

9. AGE (In years last birthday) 83
IF UNDER 1 YEAR Months 1 Days 15
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) Rockland, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James A. Ralphs
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Anna M. Jensen
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-40-4228

17. INFORMANT'S OWN SIGNATURE Mina L. Ralphs
ADDRESS Rockland, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4028

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Recurrent small pulmonary emboli — 1 yr.
DUE TO (c) Essential hypertension & mild cardiac decompensation — 8 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 26, *19* 62, *to* Jan 1, *19* 69, *that I last saw the deceased alive on* Jan 1, *19* 69, *and that death occurred at* 2:35P *m., from the causes and on the date stated above.*

23a. SIGNATURE L. L. Harris 203 (Degree or title) M.D.

23b. ADDRESS 213 Idaho St. American Falls Idaho

23c. DATE SIGNED 11-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial

24b. DATE 11-5-69

24c. NAME OF CEMETERY OR CREMATORY Valley View Cemetery

24d. LOCATION (City, town, or county) Rockland, Idaho (State)

DATE REC'D BY LOCAL REG. November 12, 1969

REGISTRAR'S SIGNATURE Irene Deeg

29. EMBALMER H. L. Davis

LICENSE NO. E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 25 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5368
Local Reg. No. 20
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED
NOV 26 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Power 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY IN THIS PLACE: 40 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 37

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MELISSA	JANE	ROBARTS	Nov. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Widowed	Oct. 27, 1887	82	0	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife, Clerk 25	Home, Retail Stores	Mountain Grove, Mo.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Melton	So. Carolina	Melissa Stone	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-09-3274A	Ruth A. Helstrom	Poc. Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Hepatic failure	2 wks
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Intrahepatic disease	3 wks
DUE TO (c)	Metastatic cardinomatosis	3 months
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Essential hypertension Cardiac failure	8 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 2, *19* 69, *to* Nov 15, *19*69, *that I last saw the deceased alive on* Nov. 14, *19*69, *and that death occurred at* 7:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F. L. Harris 203 M D	American Falls, Idaho	20 Nov. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-18-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-24-69	Irene Dilley	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 2 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5369
Local Reg. No. 21
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED
NOV 28 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location): Polk St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ROBERT	ALVA	ALBERT	Nov. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Married	Aug. 18, 1884	85	3	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant 22	Second Hand Store	Amarillo, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Albert	Oklahoma	Florence Wray	Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		542-16-3558A	Barney L. Albert	Am. Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute coronary occlusion	10 min
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Emphysema and pulmonary sclerosis	15 years
DUE TO (c)	Diabetes melitus	10 years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Duodenal ulcers	16 years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	None	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 19, 1969, *to* Nov. 20, 1969, *that I last saw the deceased alive on* Nov. 19, 1969, *and that death occurred at* 8:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. L. Harris 259	M.D.	American Falls, Idaho	21 Nov. '69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-25-69	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-25-69	Irene Daley	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 1 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 17 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-6277 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5370
Local Reg. No. 86
Reg. Dist. No. 1421

BIRTH NO.

DEC 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 401
b. CITY OR TOWN Kellogg
c. LENGTH OF STAY (In this place) D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 401
c. CITY OR TOWN Pinehurst
d. STREET ADDRESS (If rural, give location) Box 1004, Wier Gulch

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	PAMELA	ANDORA	KELLY	Oct. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	never married	June 3, 1969		4	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
never employed 62	---	Kellogg, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gerald Kelly	Idaho	Barbara Davis	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No ---	None	X Gerald Lee Kelly	Pinehurst, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden Death Syndrome (SDS) of infancy (Crib Death) — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ____

DUE TO (c) ____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-31, 1969, *to* 10-31, 1969, *that I last saw the deceased alive on* 10-31, 1969, *and that death occurred at* about 9:34 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
C. M. Peterson, M.D. 414 (Degree or title)	Wallace Idaho	12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 3, 1969	Shoshone Memorial	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
		Dan D Peterson	E-534

FIRM NAME Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service
FORM UH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5371
Local Reg. No. 175
Reg. Dist. No. 140

BIRTH NO.

RECEIVED NOV 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 402 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Montana 27
b. COUNTY Mineral 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) DeBorgia
d. STREET ADDRESS (If rural, give location) P.O. Box 23

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Laila	Inola	Kallio	11	1	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	June 6, 1927	42				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Housewife	Mullan, Idaho	usa

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Philip Kangus	Finland	Hilda Petersen	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		517-24-2703	X [illegible]	Butte Mont.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart disease 4169

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypothyroidism

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
(a) Hours.
(b) Years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-27-65, 19___, *to* 11-1-69, 19___, *that I last saw the deceased alive on* 11-1-69, 19___, *and that death occurred at* 11:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Wallace Idaho.	11-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11-5-1969	Sunset Memorial Gardens	Butte, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-69	Hale Cornell	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5372
Local Reg. No. 176
Reg. Dist. No. 140

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

NOV 12 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osburn
d. STREET ADDRESS (If rural, give location): Box 577

3. NAME OF DECEASED (Type or Print)
a. (First): Allen
b. (Middle): B.
c. (Last): Mason

4. DATE OF DEATH (Month) (Day) (Year): Nov. 1, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 15, 1889
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): Cass Co., Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Mason — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Martha Welch — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -----
16. SOCIAL SECURITY NO.: 503-16-1538A
17. INFORMANT'S OWN SIGNATURE: X Thomas M Mason — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS: Coronary Disease
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac Decompensation

19a. DATE OF OPERATION: Oct 31, 1969
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967, 19__, *to* Nov 1, 1969, *that I last saw the deceased alive on* Nov 1, 1969, *and that death occurred at* 1:25 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: N. E. Bourbaker 052 (Degree or title) MD
23b. ADDRESS: Kellogg Idaho
23c. DATE SIGNED: Nov 6, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 8, 1969
24c. NAME OF CEMETERY OR CREMATORY: Osburn Cemetery
24d. LOCATION (City, town, or county) (State): Osburn, Idaho

DATE REC'D BY LOCAL REG.: 11-10-69
REGISTRAR'S SIGNATURE: Dale L Cornell
25. EMBALMER: Dale L. Cornell — LICENSE NO.: E - 406
FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5373
Local Reg. No. 177
Reg. Dist. No. 140

Certificate of Death

RECEIVED
NOV 12 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone County Nursing Home 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Gwendolyn
b. (Middle)
c. (Last) Baker

4. DATE OF DEATH (Month) (Day) (Year) Nove. 2, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Nov. 13, 1881
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Wapello, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) -------
16. SOCIAL SECURITY NO. 518-42-6797D
17. INFORMANT'S OWN SIGNATURE X Geraldine Baker Vance — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebro Vascular Sclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* Nov 2, 1969, *that I last saw the deceased alive on* Nov 1, 1969, *and that death occurred at* 8:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE D. E. Bonebrake 052 (Degree or title) MD
23b. ADDRESS Kellogg, Idaho
23c. DATE SIGNED Nov 5, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE Nov. 7, 1969
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) Gooding, Idaho (State)

DATE REC'D BY LOCAL REG. 11-10-69
REGISTRAR'S SIGNATURE Dale Cornell
25. EMBALMER Dale L. Cornell — LICENSE NO. E - 406

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5374
Local Reg. No. 121
Reg. Dist. No. 146

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 14 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 402
b. CITY OR TOWN Silverton
c. LENGTH OF STAY (In this Place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) c. (Last) Ollila

4. DATE OF DEATH (Month) (Day) (Year) November 2, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 1, 1890

9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shaft Miner 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Finland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Uknown BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-01-6851

17. INFORMANT'S OWN SIGNATURE X Bruno E. Ollila ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: One minute

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Hypertensive C.V.R. Disease — 6-7 years

DUE TO (c) Coronary Sclerosis + Insufficiency — 6-7 years

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-26, 1963 *to* 11-2, 1969, *that I last saw the deceased alive on* 11-2, 1969, *and that death occurred at* 2:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE J. M. Peterson, M.D. (Degree or title)

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED 11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE 11-5-69

24c. NAME OF CEMETERY OR CREMATORY Smith Funeral Home

24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. 11-11-69

REGISTRAR'S SIGNATURE Dale Cornell

25. EMBALMER Dale L. Cornell

LICENSE NO. E - 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5375
Local Reg. No. 174
Reg. Dist. No. 140

BIRTH NO.

RECEIVED NOV 12 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 48
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
LENGTH OF STAY (in this place):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Yakima 535
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sunnyside

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East Shoshone Hospital 138
d. STREET ADDRESS (If rural, give location): 900 Lincoln Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Minnie; b. (Middle); c. (Last) Winchel

4. DATE OF DEATH (Month) (Day) (Year): Nov. 2, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: May 2, 1895

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 516-01-0294

17. INFORMANT'S OWN SIGNATURE: Minnie M Winchel
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Chronic cholecystitis and cholelithiasis — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/29/69, 19__, *to* 11/2/69, 19__, *that I last saw the deceased alive on* 11/2/69, 19__, *and that death occurred at* 11:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Kent J Cornell md 435 (Degree or title)

23b. ADDRESS: Wallace, Idaho

23c. DATE SIGNED: 11/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: Nov. 5, 1969

24c. NAME OF CEMETERY OR CREMATORY: Memorial Gardens

24d. LOCATION (City, town, or county) (State): Sunnyside, Washington

DATE REC'D BY LOCAL REG.: 11-4-69

REGISTRAR'S SIGNATURE: Dale Cornell

25. EMBALMER: Dale L. Cornell

LICENSE NO.: E - 406

FIRM NAME: Cornell's Ward Funeral HOme

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5376
Local Reg. No. 179
Reg. Dist. No. 140

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 20 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) County Nursing Home 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Molly
b. (Middle)
c. (Last) Grove

4. DATE OF DEATH (Month) (Day) (Year) November 7, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Oct. 14, 1893
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Van Buron, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 516-20-8604A
17. INFORMANT'S OWN SIGNATURE Hospital Records — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Diabetes Mellitus — Several years
DUE TO (c) Hypertensive C.V.R. Disease — Several years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Old Posterior Wall Myocardial Infarction — Several years ago
Emphysema, Severe — Several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-18-, 1967, *to* 11-7-, 1969, *that I last saw the deceased alive on* 11-7, 1969, *and that death occurred at* 12:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE A. M. Peterson, M.D. 414 (Degree or title)
23b. ADDRESS Wallace Idaho
23c. DATE SIGNED 11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-1169
24c. NAME OF CEMETERY OR CREMATORY Mullan Cemetery
24d. LOCATION (City, town, or county) (State) Mullan, Idaho

DATE REC'D BY LOCAL REG. 11-18-69
REGISTRAR'S SIGNATURE Blair L Cornell
25. EMBALMER Derrel J. Juelfs
LICENSE NO. E - 518

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5377
Local Reg. No. 87
Reg. Dist. No. 142

BIRTH NO.

RECEIVED DEC 11 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (In this place): 21 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shoshone County Infirmary 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wardner
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLARA	LEAFY	COULTER	November 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed	Oct. 28, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Allen VanCleve		Sarah Ann Slagle	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-60-9929	X Lo Retta Samuelson	Pinehurst, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Rheumatoid & Osteoarthritis Advanced — Many years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Influenza (2 weeks) Extremely Severe — about 6 yrs.
DUE TO (c) Acute & Chronic Urinary Tract Infection — 21 years
Acute & Chronic Gastro Intestinal Dysfunction — 21 years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prolapsed Uterus — Many years.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 1, 1960, *to* 11-16, 1969, *that I last saw the deceased alive on* 11-16, 1969, *and that death occurred at* 4:56 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. M. Peterson, M. D.	Wallace Idaho	11-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 18, 1969	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-28-69	Joe Hutchins	Russell Mikel	E-520

FIRM NAME: Cornell's Maisel Fun'l. Ch.

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 12 1969

SEP 14 1981

MAY 20 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5378
Local Reg. No. 83
Reg. Dist. No. 142

BIRTH NO.

RECEIVED DEC 11 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (In this place) 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 801 S. Hill St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Gabriel	-	Marco	Nov. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Apr. 13, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Enego, Italy	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
	Italy		Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-32-5776	Mrs Margaret Marco	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Comminuted fracture of neck + intertrochanteric region of L. femur — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure and bilateral pneumonitis — 3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (3401) (COUNTY) (STATE)
Accident	near home 01	Kellogg, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
NOV 14, 1969 9 a.m.		Knocked down by big, friendly puppy

22. I hereby certify that I attended the deceased from 14 November, 19 69, to 18 November, 19 69, that I last saw the deceased alive on 18 November, 19 69, and that death occurred at 1 00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert H. Cordwell, MD (105)	Kellogg, Idaho	12/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/21/1969	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-18-69	Joe Devine	Dean H. Petersen	E 534

FIRM NAME: Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5379
Local Reg. No. 180
Reg. Dist. No. 140

RECEIVED DEC 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): 111 Bank St.

3. NAME OF DECEASED (Type or Print): a. (First) Vena b. (Middle) May c. (Last) Gardner

4. DATE OF DEATH (Month) (Day) (Year): November 20, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 5, 1902

9. AGE (In years last birthday): 67
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Manager 26

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): Ada County, North Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Elma Paris
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-03-5279

17. INFORMANT'S OWN SIGNATURE: Norman A. Gardner
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 7 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1:10-68, 19___, *to* 11-20-69, 19___, *that I last saw the deceased alive on* 11-20-69 19___, *and that death occurred at* 11:45a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Box 200 Wallace, Idaho

23c. DATE SIGNED: 11-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-25-69

24c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery

24d. LOCATION (City, town, or county) (State): Baker, Oregon

DATE REC'D BY LOCAL REG.: 11-26-69

REGISTRAR'S SIGNATURE: Dale Harnell

25. EMBALMER: Derrell J. Juelfs
LICENSE NO.: E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5380
Local Reg. No. 83
Reg. Dist. No. 142

BIRTH NO.

RECEIVED DEC 11 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (In this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Smelterville
d. STREET ADDRESS (If rural, give location) 105 E Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILLIAM	---	HANSON	Nov. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	Aug. 25, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 11	Construction	Monches, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John M. Hanson	unknown	Karen Stenersen	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	518-16-3377	× Donald Boswell	Pinehurst, Id.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Peritonitis due Perforated viscus — 36 hrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov 21 1969	Perforation of Cecum	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 21, 1969, to Nov 23, 1969, that I last saw the deceased alive on Nov 23, 1969, and that death occurred at 3:25 a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. Cornell Smith MD 461	Kellogg Idaho	11/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 25, 1969	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-1-69	[signature]	Russell D. Maisel	E-520

FIRM NAME Cornell's Maisel Funeral Ch.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5381
Local Reg. No. 181
Reg. Dist. No. 140

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Shoshone 402 DEC 3 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace, Bureau of Vital Statistics
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) #3 Shoshone Bldg.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) #3 Shoshone Bldg.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Walter	Lee	Scott	Nov. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct. 9, 1902	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Northern Pacific	Railroad	Remini, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
D. R. Scott	Unknown	Eda Hennessey	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	566-18-1529	Thelma Scott	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema & Asthma — 8 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-23 1969 *to* 11-23, 1969, *that I last saw the deceased alive on* 11-23, 1969 *and that death occurred at about* 2:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. M. Peterson M.D.	Wallace, Idaho	11-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-26-69	Mullan Cemetery	Mullan, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-1-69	Dale Cornell	Dale L. Cornell	E-406

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 11 1969 Bureau of Vital Statistics

State File No. 5382
Local Reg. No. 85
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Shoshone 401	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg; c. LENGTH OF STAY (In this place) Minutes	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. West Shoshone Gen. 141	d. STREET ADDRESS (If rural, give location) 220 E. Cameron

3. NAME OF DECEASED (Type or Print) a. (First) Viola	b. (Middle)	c. (Last) Tyree	4. DATE OF DEATH (Month) (Day) (Year) November 25, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 30, 1905	9. AGE (In years last birthday) 63 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse 13	10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Starks	BIRTHPLACE Missouri	14. MOTHER'S MAIDEN NAME Mary Long	BIRTHPLACE Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 444-16-5172	17. INFORMANT'S OWN SIGNATURE X Jack Tyrel	ADDRESS Kellogg, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-25, 1969, *to* 11-25, 1969, *that I last saw the deceased alive on* 11-25, 1969, *and that death occurred at* 7:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE A. M. Peterson, M.D. 414 (Degree or title)	23b. ADDRESS Wallace, Idaho	23c. DATE SIGNED 11-28-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE Nov. 28, 1969	24c. NAME OF CEMETERY OR CREMATORY Melrose
24d. LOCATION (City, town, or county) (State) Melrose, Kansas		
DATE REC'D BY LOCAL REG. 12-2-69	REGISTRAR'S SIGNATURE Joe Dahne	25. EMBALMER Dean H. Petersen
LICENSE NO. E 534		

FIRM NAME Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969
FEB 17 1970
OCT 14 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5383
Local Reg. No. 84
Reg. Dist. No. 142

RECEIVED DEC 11 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (In this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
d. STREET ADDRESS (If rural, give location) Moon Gulch

3. NAME OF DECEASED (Type or Print) a. (First) MILFERD b. (Middle) ARTHUR c. (Last) CHAPIN

4. DATE OF DEATH (Month) (Day) (Year) Nov. 26, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH March 3, 1908
9. AGE (In years last birthday) 61 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) smelterman 07
10b. KIND OF BUSINESS OR INDUSTRY mining
11. BIRTHPLACE (State or foreign country) Frenchtown, Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Chapin BIRTHPLACE Montana
14. MOTHER'S MAIDEN NAME Florence BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II 4
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE X Bertha Chapin ADDRESS Kellogg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 30 minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ca of Lung — 1 year

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Kellogg (COUNTY) Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1955, *to* 11/26, 1965, *that I last saw the deceased alive on* 11/26, 1969, *and that death occurred at* 9:55 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Glen M. Whiteset 534 (Degree or title) MD
23b. ADDRESS Kellogg, Idaho
23c. DATE SIGNED 30 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 29, 1969
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg, Idaho (State)

DATE REC'D BY LOCAL REG. 12-1-69
REGISTRAR'S SIGNATURE Joe Levine
25. EMBALMER Russell D. Maisel
LICENSE NO. E-520

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME Cornell's Maisel Funeral Ch.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969
DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 8 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5384
Local Reg. No. 182
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 225 Pine St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): 225 Pine St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Kathryn	Tabor	Osborne	Nov.	28,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Oct. 31, 1902	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Office Work 07	Shunshine Mining Co.	Wallace, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jene Tabor	Unknown	Cathrine Robertson	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-28-9996	Kathryn W. Osborne	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-28-60, 19____, *to* 11-28-69 19____, *that I last saw the deceased alive on* 11-14-69, 19____, *and that death occurred at* 2:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Box 200 Wallace, Idaho	11-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	12-29-69	Smith Funeral Home	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-4-69	[signature]	Derrell J. Juelfs	E-518

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornelll's Ward Funeral Home

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 11 1969 Bureau of Vital Statistics

State File No. 5385
Local Reg. No. 89
Reg. Dist. No. 142

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Shoshone (402)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (In this place): Mons.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shoshone Co. Nursing Home (344)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Shoshone (402)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 301 E. Portland

3. NAME OF DECEASED (Type or Print): a. (First) Elizabeth; b. (Middle); c. (Last) Griffin

4. DATE OF DEATH (Month) (Day) (Year): Nov. 30, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 28, 1897

9. AGE (In years last birthday): 72
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (01)

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Hay
BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Margaret Morrison
BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-16-3427

17. INFORMANT'S OWN SIGNATURE: Ralph Forsen
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Massive Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic Heart Disease — 4 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Healed Myocardial Infarct

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg Shoshone Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1948 *to* 11/30 1969, *that I last saw the deceased alive on* 11/29 1969, *and that death occurred at* 11:09 m., *from the causes and on the date stated above.*

23a. SIGNATURE: Allen M. Whitten (534) (Degree or title): M.D.

23b. ADDRESS: Kellogg, Idaho

23c. DATE SIGNED: 12/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation[3]

24b. DATE: 12/3/1969

24c. NAME OF CEMETERY OR CREMATORY: Smith & Co.

24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 12-5-69

REGISTRAR'S SIGNATURE: Joe Sabine

25. EMBALMER: Alan D. Petersen

LICENSE NO.: E 534

FIRM NAME: Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5386
Local Reg. No. 7
Reg. Dist. No. 620

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Teton 410 NOV 24 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) DOA at Driggs
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Victor
d. STREET ADDRESS (If rural, give location) none given

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	Gary	Henry	Matkin

4. DATE OF DEATH (Month) (Day) (Year) November 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	never married	June 3, 1954	15				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student 33	- - -	Driggs, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lloyd Henry Matkin	Hyde Park, Utah	Geneva Weelstenhulme	Driggs, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	none	* Floyd H. Matkin	Victor, Ida=

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe head injury — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Highway 06	Victor,	Teton,	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21f. HOW DID INJURY OCCUR?
Nov. 4, 69 8P.m.		Car Accident

22. I hereby certify that I attended the deceased from _____, 19 61, to _____, 19 69, that I last saw the deceased alive on Nov 4, 1969, and that death occurred at 8:30 p. m. from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
K Lloyd MD	219	Driggs Idaho	11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 7, 1969	Victor Cemetery	Victor, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-69	Ella Driggs	Robert Bean	E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended December 19, 1969

Certificate of Death
STATE OF IDAHO

State File No. 5387
Local Reg. No. 8
Reg. Dist. No. 620

BIRTH No.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (In this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs, rural area
d. STREET ADDRESS (If rural, give location): 2 mi East of Driggs

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Willard	James	Casper	November 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 2, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Lewisville, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Reuben M. Casper	East Mill Creek, Utah	Elizabeth Arrowsmith	Cottonwood, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	-----	518-38-7788	Lorin W. Casper	Driggs, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ca of stomach — INTERVAL BETWEEN ONSET AND DEATH: 9 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 8, 19 69, *to* death, 19____, *that I last saw the deceased alive on* Nov 8, 19 69, *and that death occurred at* 3:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
K Head, M.D. 219	Driggs, Idaho	11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Nov 10, 1969	Pratt Cemetery	Alta, Wyo via Driggs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-69	Ella Griggs	Robert Q. Bean	E 456

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Robert Bean Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

RECEIVED
DEC 19 1969
Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho
County of Teton } ss.

Certificate No. 8

Date Filed 11-20-69

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death) for Willard James Casper (Name on Original Certificate) who died (Was Born or Died) on Nov 8, 1969 (Date of Event) in Driggs, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#24C Name of Cemetery	Driggs Cemetery	Pratt Cemetery
#24d Location	near Driggs, Idaho	Alta Wyo.
		Victor, Idaho

Subscribed and sworn to before me this 12th day of December, 1969

Notary Public, residing at Driggs

My commission expires July 10, 1971

(Seal)

Signed Robert Dean

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Driggs Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Teton } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 12th day of December, 1969

Notary Public, residing at Driggs

My commission expires July 10, 1971

(Seal)

Signed Dorothy Casper

(Signature of Any Credible Person)

Driggs, Idaho

(Street Address, City, State)

FORM DH 60-155

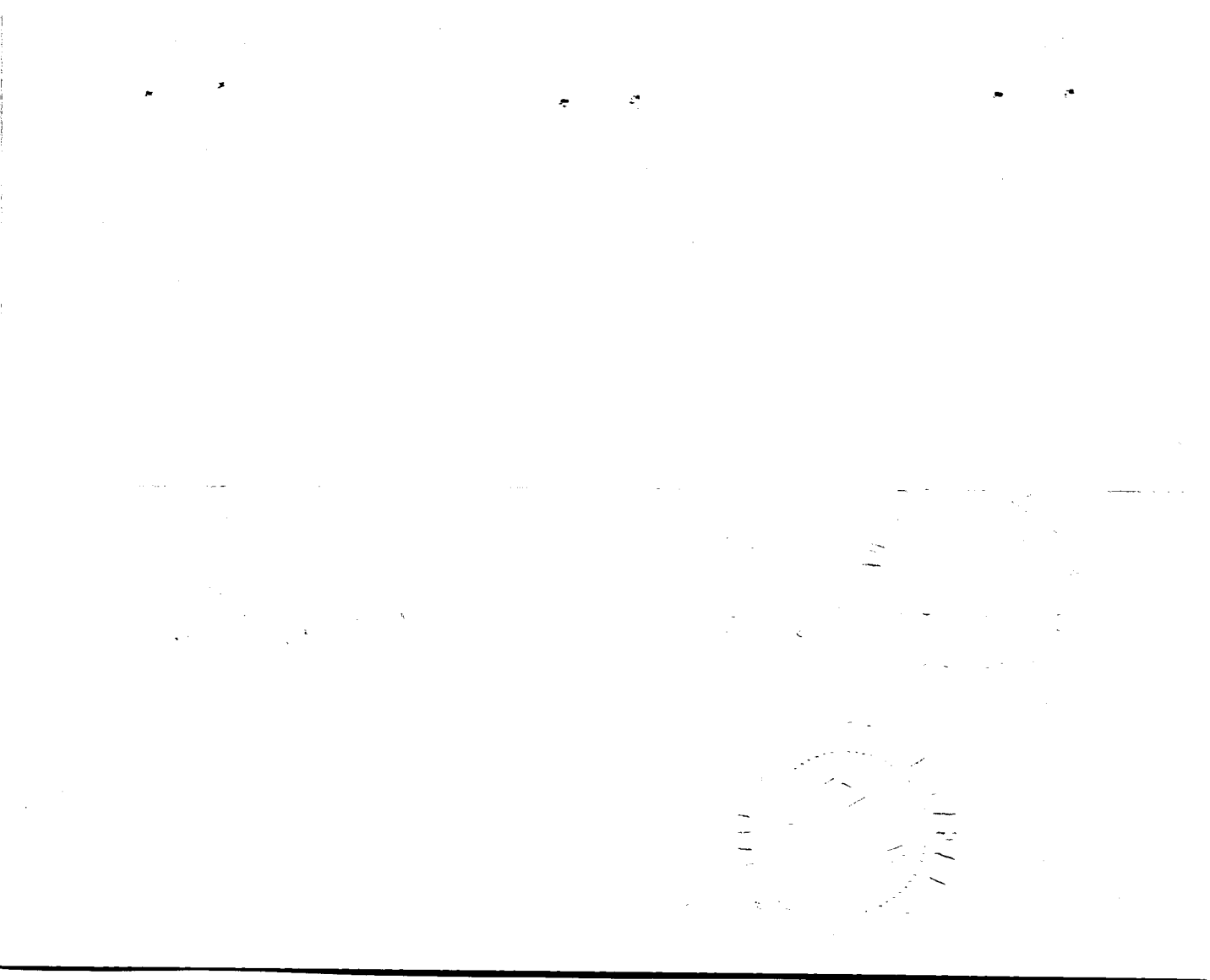

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 8
Reg. Dist. No. 620

RECEIVED
NOV 24 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Teton
b. CITY OR TOWN: Driggs (If outside corporate limits, write RURAL and give township)
STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital ~~His home in rural Driggs~~

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton
c. CITY OR TOWN: Driggs rural area
d. STREET ADDRESS (If rural, give location): 2 mi East of Driggs

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Willard	James	Casper	Nov 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	married	July 2, 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Agriculture	Lewisville, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Reuben M. Casper	East Mill Creek, Utah	Elizabeth Arrowsmith	Cottonwood, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-------	518-38-7788	X Tom W. Casper	Driggs, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of stomach — INTERVAL BETWEEN ONSET AND DEATH: 9 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 8, 1969, *to* death 19___, *that I last saw the deceased alive on* Nov 8, 19 69 *and that death occurred at* 3:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
K Heud MD	Driggs Idaho	11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 10, 1969	Driggs Cemetery	near Driggs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-69	Ella Driggs	Robert Bean	E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 14 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5388
Local Reg. No.
Reg. Dist. No. 620

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Teton — NOV 24 1969 — b. CITY OR TOWN: Driggs — LENGTH OF STAY (In this place): 1 wk — d. FULL NAME OF HOSPITAL OR INSTITUTION: Teton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho — b. COUNTY: Teton — c. CITY OR TOWN: Driggs — d. STREET ADDRESS (If rural, give location): Main Street

3. NAME OF DECEASED (Type or Print): a. (First) Sarah — b. (Middle) Naomi — c. (Last) Larsen

4. DATE OF DEATH: (Month) (Day) (Year): Nov 11, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 15, 1901

9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Marion, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Peter Sorensen — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Lewis — BIRTHPLACE: Kamas, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-05-6464B

17. INFORMANT'S OWN SIGNATURE: X Aldrich Larsen — ADDRESS: Driggs, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 4319 Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 Day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1961, *to* ____, 1969, *that I last saw the deceased alive on* Nov 11, 1969, *and that death occurred at* 4:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K Hand MD

23b. ADDRESS: Driggs, Idaho

23c. DATE SIGNED: 11-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov 14, 1969

24c. NAME OF CEMETERY OR CREMATORY: Darby Cemetery

24d. LOCATION (City, town, or county) (State): near Driggs, Teton Co., Idaho

DATE REC'D BY LOCAL REG.: 11-20-69

REGISTRAR'S SIGNATURE: Ella Driggs

25. EMBALMER: Robert Bean

LICENSE NO.: E456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5389
Local Reg. No. 10
Reg. Dist. No. 620

Certificate of Death

RECEIVED
DEC 2 1969
Bureau of Vital Stat.

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): home - 51 No. 1st Main

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
d. STREET ADDRESS (If rural, give location): 51 No. 1 Main

3. NAME OF DECEASED (Type or Print)
a. (First): Eva
b. (Middle): B.
c. (Last): Hillman

4. DATE OF DEATH (Month) (Day) (Year): Nov 17, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan 12, 1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Eureka, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Alfred Buxton — BIRTHPLACE: Richmond, Utah
14. MOTHER'S MAIDEN NAME: Martha Alice Carson — BIRTHPLACE: Richmond, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 519-03-9045D
17. INFORMANT'S OWN SIGNATURE: Russell G. Hillman — ADDRESS: St. Anthony, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASCVD — 5 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: diabetes mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1961, *to* death, *that I last saw the deceased alive on* Nov 16, 1969, *and that death occurred at* 9:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K Head MD
23b. ADDRESS: Driggs Idaho
23c. DATE SIGNED: 11-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Darby Demetery
24d. LOCATION (City, town, or county) (State): near Driggs, Idaho

DATE REC'D BY LOCAL REG.: 11-29-69
REGISTRAR'S SIGNATURE: Ella Griggs
25. EMBALMER: Robert Bean — LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robert Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 20 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5390
Local Reg. No. D-356
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 NOV 6 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 401 2nd Avenue East

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Eden
d. STREET ADDRESS (If rural, give location) R.R.#1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HARRY	ALBERT	AGEE	November 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Sept. 11, 1943	26				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 54		Twin Falls, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lester Agee	Wells, Nevada	Dorothy Pearl Bricker	Mackay, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-52-6404	Mrs. Harry A. Agee	Eden, Idaho

MEDICAL CERTIFICATION

965X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound in upper chest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Internal hemorrhage due to severing — Instant

DUE TO (c) of superior vena cava.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
3 Homicide	apartment bldg. 31	Twin Falls 1342 Twin Falls, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Nov. 1, 1969 1120 a.m.		Gunshot wound in chest

22. *I hereby certify that I attended the deceased from* Coroner's investigation only *19___, that I last saw the deceased alive on ___, 19___, and that death occurred at* 1120a. *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Cloyce O. Edwards 583 4	Coroner	Twin Falls, Idaho	11/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/4/69	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 4, 1969	Marva D. Marsh	Paul D. Reynolds	495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5391
Local Reg. No. D-364
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Idaho 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazeldel Manor Nursing Home 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 140 9th Av. North

3. NAME OF DECEASED (Type or Print): a. (First) ALBERT; b. (Middle) BARR; c. (Last) COLWELL

4. DATE OF DEATH (Month) (Day) (Year): November 1, 1969

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 18, 1874

9. AGE (In years last birthday): 95
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Druggist 21

10b. KIND OF BUSINESS OR INDUSTRY: Pharmacy

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: MILES COLWELL
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: AMANDA BARR
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-54-0399J1

17. INFORMANT'S OWN SIGNATURE: x Katherine C. Belko
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4123 Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) c Chronic Brain Syndrome
DUE TO (c) Arteriosclerotic Heart Disease — 10 Years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus 15 yrs / 3 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Comminuted fracture of wrist
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1958, *to* Nov. 1, 1969, *that I last saw the deceased alive on* October 31, 1969, *and that death occurred at* 8:40P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 578 (Degree or title): M.D.
23b. ADDRESS: 204 4th Ave. E. Twin Falls, Ida.
23c. DATE SIGNED: 11/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 5, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 11-5-69
REGISTRAR'S SIGNATURE: Vera Ryals
25. EMBALMER: Jerry D. Holman
LICENSE NO.: E-516
FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 7 1969

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5392
Local Reg. No. D-362
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 6 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 287 Sunny View Cts.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARGARET	FISKE		Nov. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	July 24, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	Kingston, New York	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Francis Middleton	Peterhead, Scotland	Hopkins Mairer	Aberdeen, Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	518-68-7344	+Donald F. Fiske	Long Beach, California

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

188X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Six Mons.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of bladder, transitional cell — 8 Mons.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive C.V. Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-15 , 19 65 , *to* 11-1 , 19 69 , *that I last saw the deceased alive on* 10-31- , 19 69 , *and that death occurred at* 4:50a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George E. Brown 061 MD	Twin Falls, Idaho	11-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 4, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-5-69	Vera Ryals	Edgar J. Robertson	E-507

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5393
Local Reg. No. D 357
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): R.R.#3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: T.Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Twin Falls
d. STREET ADDRESS (If rural, give location): R.R.#3

3. NAME OF DECEASED (Type or Print): a. (First) DEAN b. (Middle) c. (Last) MILLER

4. DATE OF DEATH (Month) (Day) (Year): November 1,1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: June 28,1883

9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oceola,Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: M.W.Miller — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-07-9051 A

17. INFORMANT'S OWN SIGNATURE Mrs Al Hankins ADDRESS Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriorsclerotic Heart disease

DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Deficiency anemia

19a. DATE OF OPERATION: 10/25/69

19b. MAJOR FINDINGS OF OPERATION: Impacted fracture of the distal radius with angulation of the distal radius dorsally.

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9/12, 1961, *to* 11/1/, 1969, *that I last saw the deceased alive on* 10/31, 1969, *and that death occurred at* 4:45p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Twin Falls,Idaho

23c. DATE SIGNED: 11/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/5/69

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls,Idaho

DATE REC'D BY LOCAL REG.: Nov. 4, 1969

REGISTRAR'S SIGNATURE: Marva A. Marsh

25. EMBALMER: Paul D. Reynolds

LICENSE NO.: E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 10 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5394
Local Reg. No. D-370
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazeldel Manor 255

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer
d. STREET ADDRESS (If rural, give location): 108 Main Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ETTA	ETHEL	GARRETT	Nov. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Aug. 10, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Medford, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Cannon	Iowa	Margaret Miller	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-14-0235	Leonard L. Garrett	P.O. Box 392, Filer, Ida.

4369

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bronchial pneumonia	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral vascular accident	3 weeks
DUE TO (c)	Generalized arteriosclerosis	5 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	None	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 9, 1969, to Nov. 2, 1969, that I last saw the deceased alive on Nov. 2, 1969, and that death occurred at 4:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. H. Clark M.D.	632 Main Av. N., Twin Falls	11/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/6/69	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	26. EMBALMER	LICENSE NO.
Nov. 6, 1969	Marva D. Marsh	Robert T. Dickard	E-312

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

DEC 2 1969
NOV 1 6 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5395
Local Reg. No. D-363
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 6 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly 83341 Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hansen 83334
d. STREET ADDRESS (If rural, give location): Route# 2

3. NAME OF DECEASED (Type or Print): a. (First) JUDSON b. (Middle) N. c. (Last) PETTYGROVE

4. DATE OF DEATH: (Month) November (Day) 3, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 21, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher- Public School	Orchestra	Oxford, Nebraska	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William T. Pettygrove	Wisconsin	Bertha Ingalsbe	Onaga, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	570-14-2657	Laura Pettygrove	Hansen, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4410 Dissecting Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 38 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Ulcers by Hx

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/3, 1969 *to* 11/3, 1969, *that I last saw the deceased alive on* 11/3, 1969, *and that death occurred at* 9.45P *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
466. Roy O. Shaub M.D. (Degree or title)	Twin Falls, Idaho	11.6.69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11.6.69	Sunset Memorial Park Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-5-69	Vera Ryals	Ronald L. Saunders	470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 1 8 1969
DEC 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 1 1 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5396
Local Reg. No. D-372
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 10 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION ~~Hosp~~ Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 363 6th Ave West

3. NAME OF DECEASED (Type or Print) a. (First) LENA b. (Middle) c. (Last) CARTER
4. DATE OF DEATH (Month) (Day) (Year) November 4, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 22, 1893
9. AGE (In years last birthday) 75
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Caldwell, Texas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John M. Mathis BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary Lucrica Hightower BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 09 3509
17. INFORMANT'S OWN SIGNATURE x Lena Carter ADDRESS TwinFalls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral vascular accident — 7 years
DUE TO (c) Generalized arteriosclerosis — 10 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Right hemiplegia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 16, 19 62, *to* November 4, 19 69, *that I last saw the deceased alive on* November 4, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE W. H. Clark-MD 042 (Degree or title)
23b. ADDRESS 632 Main Ave. N., TwinFalls, Idaho
23c. DATE SIGNED 11.5.69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11.6.69
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 11-7-69
REGISTRAR'S SIGNATURE Vera Ryals
25. EMBALMER
LICENSE NO. 343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 1 4 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 25 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5397
Local Reg. No. D-392
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN: Twin Falls
c. LENGTH OF STAY (in this place): 5 Wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital 443

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): Rural Route 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Oran	F.	Howard	Nov. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct. 15, 1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farm Owner	Colfax, Washington	U.S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joab Howard	Georgia	Sarah DeBusk	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-42-6515	Mrs Oran Howard	Buhl, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infarction of Myocardium — INTERVAL BETWEEN ONSET AND DEATH: 5 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) from Coronary Sclerosis Arteriosclerotic Heart Disease — sev yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic Passive Congestion — 5 wks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-28, 1969, *to* Nov 5, 1969, *that I last saw the deceased alive on* Nov 5, 1969 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H Anderson	MD	Buhl, Ida	11-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 8, 1969	Buhl Cemetery	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 24, 1969	Marva D. Marsh	Jim A Hopkins	E-482

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

JAN 20 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

BIRTH NO. RECEIVED NOV 25 1969 Bureau of Vital Statistics

State File No. 5398
Local Reg. No. D-389
Reg. Dist. No. 460

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (In this place): 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 204 8th Avenue North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JEHU		FENN	Nov.	6	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 25, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Canal Company	Kanosh, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frederick Fenn	England	Martha Cox	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	712-07-7207	August Averett	636 Madison Twin Falls, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: several wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — several years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-28, 1969, *to* Nov 6, 1969, *that I last saw the deceased alive on* 10-23, 1969, *and that death occurred at* 10:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H Anderson, M.D.	Buhl, Idaho	11-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11/10/69	Elmwood	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 20, 1969	Mamie D. Marsh	Robert F. Dickard	E-312

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5399
Local Reg. No. D-391
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 25 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 176 east-300 south
d. STREET ADDRESS (If rural, give location) Rupert Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) Louis Spevak
b. (Middle)
c. (Last)

4. DATE OF DEATH (Month) Nov 6 (Day) 1969 (Year)

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH June 12 1890
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Schuyler Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank John Spevak-Nebraska — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Kathrin Vlchek-Czechoslvakia — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-40-9893
17. INFORMANT'S OWN SIGNATURE x Frank J Spevak — ADDRESS Rupert Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocordial Infarction — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinomotesis — months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 20, 1969, *to* Nov 6, 1969, *that I last saw the deceased alive on* 6 Nov, 1969, *and that death occurred at* 2:35 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] 418
23b. ADDRESS Twin Falls Clinic
23c. DATE SIGNED 11/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov 10 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) Rupert Idaho (State)

DATE REC'D BY LOCAL REG. Nov 20, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Robert C Walk — LICENSE NO. E 294

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 5 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 2 1 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

NOV 13 1969

Bureau of Vital Statistics

State File No. 5400
Local Reg. No. D-396
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen 83334
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 2 South of City 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen 83334
d. STREET ADDRESS (If rural, give location) Route # 2 South of City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Howard	J.	Larsen	November 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 27, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer & Machinist	Farming	Rock Creek, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hans P. Larsen	Denmark	Mary Jensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	518-10-7782	X Nanna J. Larsen	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

203X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiple Myeloma 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April, 1946, to Nov 7, 1969, that I last saw the deceased alive on Nov 6, 1969, and that death occurred at 5:30a m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 460	MD	Twin Falls Ida	11-7-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 10, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 12, 1969	Marva D. Marsh	Jerry D. Holmes	E-516

FIRM NAME White Mortuary Twin Falls, Ida.
6600

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 17 1969

NOV 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5401
Local Reg. No. D-384
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
NOV 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 501 4th Ave. W.

3. NAME OF DECEASED (Type or Print) a. (First) PEARL b. (Middle) B. c. (Last) ROBINSON

4. DATE OF DEATH (Month) (Day) (Year) Nov. 8, 1969

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: April 5, 1875
9. AGE (In years last birthday): 94
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaking
11. BIRTHPLACE (State or foreign country): Weston, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Horace Harrington BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Ella French BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Harry Robinson ADDRESS Twin Falls, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) TERMINAL NEPHRITIS & UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 WK

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) TERMINAL BRONCHOPNEUMONIA - 1 MO
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE & MYOCARDITIS 10 YEARS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. COMPLICATING DIABETES MELLITUS 4 YEARS

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-7-69, 19____, to 11-8-69, 19____, that I last saw the deceased alive on 11-8-69, 19____, and that death occurred at 3:45p m., from the causes and on the date stated above.

23a. SIGNATURE Joseph W. Marshall 330 (Degree or title) M.D
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 11-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17, 1969
REGISTRAR'S SIGNATURE: Marva O. Marsh
25. EMBALMER: Edgar J. Robertson
LICENSE NO.: E-507
FIRM NAME: Twin Falls, Idaho White Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED NOV 13 1969 Bureau of Vital Statistics

State File No. 5402
Local Reg. No. D-377
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 126 Caswell

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Arizona 03
b. COUNTY Maricopa 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glendale
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MRS.	CATHARINE	WARD	Nov. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Jan. 31, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher 12	Teaching	Ainsworth, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clinton L. Briggs	unknown	India Clark	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	527-30-3840	X Carl E Briggs	Twin Falls, I

174 X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yr. +

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of the breast. — 6 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from August 6, 1969, to Nov. 9, 1969, that I last saw the deceased alive on Nov. 4, 1969, and that death occurred at 12:45A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
489 James H. Spafford MD	Twin Falls, Idaho	11-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Nov. 11, 1969		Glendale, Arizona

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 12, 1969	Marva D. Marsh	Edgar J. Robertson	E-507

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5403
Local Reg. No. D-382
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
NOV 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In hospital or institution): 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION: T.F Co. Perrine Memorial Bridge
Snake River Canyon

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 103 8th Ave East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LAWRENCE	JOHN	BLACK	Nov. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct. 4, 1938	31		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student Idaho State College		Twin Falls, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lelan L. Black	Desert, Utah	Rheta Lowe	Oakley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes 1960 to 1963	519-38-2356	X Jon J Black	Twin Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Multiple massive traumatic injuries to head, truck and limbs. — INTERVAL BETWEEN ONSET AND DEATH: seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Fall from Perrine Memorial Bridge into Snake River Canyon.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide	Perrine Bridge	Twin Falls county, Idaho 13420

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Nov. 10, 1969 9:30 A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	fall into Snake River Canyon.

22. I hereby certify that I attended the deceased from I did not attend deceased, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Eloyce O. Edwards (Degree or title) Coroner	Route #3 Twin Falls, Idaho	Nov. 12, 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11.12.69	Sunset Memorial Park Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-14-69	Vera Ryals	Donald D. Hamilton	E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969
DEC 1 8 1969
JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 0 8 2009

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
NOV 13 1969
Bureau of Vital Statistics

State File No. 5404
Local Reg. No. D-378
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 421 Twin Falls	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY TwinFalls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 — c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazeldel Manor 285	d. STREET ADDRESS (If rural, give location) Hazeldel Manor

3. NAME OF DECEASED (Type or Print) a. (First) ELSIE	b. (Middle) SOPHIE	c. (Last) CARLSON	4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 10,1969	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Aug.24,1887	9. AGE (In years last birthday) 82 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) FINLAND	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 531-03-4249	17. INFORMANT'S OWN SIGNATURE X Agnes L. Martin	ADDRESS TwinFalls, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Cardio vascular disease & Pulmonary edema + 20 yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Bronchopneumonia 2 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 2, 1969 *to* Nov 10, 1969 *that I last saw the deceased alive on* Nov 10, 1969 *and that death occurred at* 12 AM *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 459 (Degree or title)	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 11.11.69	
24a. BURIAL, CREMATION, REMOVAL (Specify) 3 Burial removal	24b. DATE 11.11.69	24c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery	24d. LOCATION (City, town, or county) (State) Seattle, Washington
DATE REC'D BY LOCAL REG. Nov. 12, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Edgar J. Robertson	LICENSE NO. E-507

FIRM NAME: White Mortuary TwinFalls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5405
Local Reg. No. D-380
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Twin Falls 421 — NOV 17 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Twin Falls 83301 — c. LENGTH OF STAY (In this place) Bureau of Vital Statistics	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly 83341
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143	d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print) a. (First): IDA	b. (Middle): F.	c. (Last): KRUEGER	4. DATE OF DEATH (Month) (Day) (Year): November 10, 1969	
5. SEX: FEMale	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Feb.16,1891	9. AGE (In years last birthday): 78 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): West Point, Nebraska	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Gottfried Weckert	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518 42 5843	17. INFORMANT'S OWN SIGNATURE: x Elsie Krueger	ADDRESS: Kimberly, Ida	

4188

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Myocardial Infarction	10 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertensive Arteriosclerotic Heart Disease	5 yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Old Cerebral Vascular Accident	5 yrs ago

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/18, 1968, *to* 11/11, 1969, *that I last saw the deceased alive on* 11/10, 1969, *and that death occurred at* 6:35A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Roy O Shaub MD 466 (Degree or title)	23b. ADDRESS: TwinFalls, Idaho	23c. DATE SIGNED: 11.11.69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 11.13.1969	24c. NAME OF CEMETERY OR CREMATORY: Sunset MemorialParkCem. — 24d. LOCATION (City, town, or county) (State): TwinFalls, Idaho
DATE REC'D BY LOCAL REG.: Nov. 13, 1969	REGISTRAR'S SIGNATURE: Marva D. Marsh	25. EMBALMER: Dugl W Tillon — LICENSE NO.: 343

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: White Mortuary TwinFalls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5406
Local Reg. No. D-379
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 13 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY T. Falls 421
c. CITY OR TOWN Twin Falls
d. STREET ADDRESS (If rural, give location) 2102 Falls Avenue East

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) MARTIN c. (Last) SPOHR

4. DATE OF DEATH (Month) (Day) (Year): November 10, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: January 3, 1900

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Club Operator 26

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oshkosh, Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Merl Spohr
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: unknown
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W. #2

16. SOCIAL SECURITY NO.: 519-05-8769

17. INFORMANT'S OWN SIGNATURE: Edna Le Spohr, ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Varices — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cirrhosis of the liver — 4 years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-21-, 1965, *to* 11/10/, 1969, *that I last saw the deceased alive on* 11-9-, 1969, *and that death occurred at* 6:55a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: George S. Brown, M.D. (Degree or title)
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 11-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/13/69
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov 13, 1969
REGISTRAR'S SIGNATURE: Maura D. Mark
25. EMBALMER: Paul D. Reynolds
LICENSE NO.: E-495
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 13 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5407
Local Reg. No. D-381
Reg. Dist. No. 460

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH — NOV 18 1969
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 580 Monroe

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THOMAS	JAMES	ROBERTS, JR.	November 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Aug. 22, 1931	38				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction worker	Construction	Twin Falls, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas J. Roberts, Sr.	Idaho	Alice Marie Duncan	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-30-8468	Mrs. Tom Roberts	Twin Falls, Idaho

4189

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Artery Disease	?
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Massive Coronary Thrombosis	30 Minutes
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* September 19 47, *to* Nov. 11, 19 69, *that I last saw the deceased alive on* Nov. 11, 19 69, *and that death occurred at* 1:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean H Abblett M.D.	Twin Falls, Idaho	Nov. 13, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 14, 1969	Sunset Memorial Park	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 14, 1969	Mavis D. Marsh	William L Boyd	E-490

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 26 1950

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5408
Local Reg. No. D-383
Reg. Dist. No. 460

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 17 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: T.Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 1795 4th Avenue East

3. NAME OF DECEASED (Type or Print)
a. (First): MARGARET
b. (Middle): JANE
c. (Last): PETERSON

4. DATE OF DEATH (Month) (Day) (Year): November 12, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 7, 1881
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired L.P.N. 13
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Hannibal, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: B.R.Little — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Kathryn Sandner — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-36-6146A
17. INFORMANT'S OWN SIGNATURE: Jeanette Wiley — Twin Falls, Idaho — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

486X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Terminal pneumonia~~ Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: X weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. chronic brain syndrome — 8 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: from cerebral arteriosclerosis
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 30, 1963, *to* 11/12/, 1969, *that I last saw the deceased alive on* 10/8/68, 19__, *and that death occurred at* 1:20a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 11/13/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/14/69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 11/14/69
REGISTRAR'S SIGNATURE: [signature] Vera Ryals
25. EMBALMER: Paul D. Reynolds — [signature]
LICENSE NO.: E-495

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5409
Local Reg. No. D-382
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 18 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 525 Washington St. North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 525 Washington St. North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DEBRA	GAIL	CLAPPER	November 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	April 26, 1951	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Nome	Burlington, Vermont	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Landon H. Billado	Jeffersonville, Vt.	Ida Ferrari	Ostiglia, Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-64-5378	X Ida McCauley	Twin Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 2001 Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 19 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 4-2, 19 69, to 11-13, 19 69, that I last saw the deceased alive on 11-5, 19 69, and that death occurred at 12:30p m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Roy O. SWAN 466	M.D.	Twin Falls, Idaho	11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 15, 1969	Twin Falls Cemetery	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 17, 1969	Marva D. Marsh	Jerry L. Holman	E-516

FIRM NAME: White Mortuary, Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

MAR 2 0 1970
FEB 2 5 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED NOV 25 1969 Bureau of Vital Statistics

State File No. 5410
Local Reg. No. D-387
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
IF NOT IN THIS PLACE: LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly 83341
d. STREET ADDRESS (If rural, give location) 120 2nd St. West

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) E. c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1969

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept. 12, 1887

9. AGE (In years last birthday) 82
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Berryville, Arkansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Smith BIRTHPLACE Arkansas

14. MOTHER'S MAIDEN NAME Nancy Carr BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ----

16. SOCIAL SECURITY NO. 519-01-9711

17. INFORMANT'S OWN SIGNATURE Esther Graff ADDRESS Murtaugh, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchogenic CA

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, Hypertension

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Thoracentesis - Malignant cells

20. AUTOPSY? Yes X No

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 1:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE 420 (Degree or title) MD

23b. ADDRESS Kimberly, Idaho 83341

23c. DATE SIGNED 11/17/1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 15, 1969

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 18, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Ronald J. Hamilton

LICENSE NO. E-470

FIRM NAME: White Mortuary
Twin Falls, Idaho 733-6600

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 25 1963

MAY 04 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5411
Local Reg. No. D-385
Reg. Dist. No. 460

BIRTH NO.

NOV 18 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 c. LENGTH OF STAY (If in this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen 83334
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143	d. STREET ADDRESS (If rural, give location) 105 2nd. Street East

3. NAME OF DECEASED (Type or Print) a. (First) ROSE	b. (Middle)	c. (Last) WISEMAN	4. DATE OF DEATH (Month) (Day) (Year) November 13, 1969	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 24, 1900	9. AGE (In years last birthday) 69 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Wyoming	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown Gaspard	BIRTHPLACE unknown	14. MOTHER'S MAIDEN NAME unknown	BIRTHPLACE unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-30-8311	17. INFORMANT'S OWN SIGNATURE Dorothy M. Taylor	ADDRESS Aurora, Illinois	

5741

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Heart Failure	4 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Complication of Gall	
DUE TO (c)	Bladder Surgery —	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	High Blood pressure.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Gall Stones — Cholecystitis	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1963 *to* Nov 13, 1969, *that I last saw the deceased alive on* Nov 13, 1969, *and that death occurred at* 11:35P *m., from the causes and on the date stated above.*

23a. SIGNATURE 417 [signature] (Degree or title)	23b. ADDRESS 542 Main So. Twin Falls	23c. DATE SIGNED Nov 14, 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 17, 1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho
DATE REC'D BY LOCAL REG. Nov. 17, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Jerry D. Holman	LICENSE NO. E-516

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5412
Local Reg. No. D-390
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 25 1969 Bureau of Vital Statistics

1. PLACE OF DEATH 421
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY T.Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 459 2nd Avenue North

3. NAME OF DECEASED (Type or Print)
a. (First) JAMES
b. (Middle) H.
c. (Last) DONALD

4. DATE OF DEATH (Month) (Day) (Year) November 14,1969

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH November 6,1892
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.Custodian 06
10b. KIND OF BUSINESS OR INDUSTRY Apt.House
11. BIRTHPLACE (State or foreign country) Greenville,South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Donald — BIRTHPLACE South Carolina
14. MOTHER'S MAIDEN NAME Bettie Moore — BIRTHPLACE South Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-07-9925A
17. INFORMANT'S OWN SIGNATURE Chicago, Geneva Cunningham — ADDRESS Illinois

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 1 mon.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Diplococcal Meningitis — 1 mon.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diplococcal Pneumonia. — 1 mon.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/19, 1969, *to* 11/14/, 1969, *that I last saw the deceased alive on* 11/14, 1969, *and that death occurred at* 7:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Roy O. Shaub 466 (Degree or title) M.D.
23b. ADDRESS Twin Falls,Idaho
23c. DATE SIGNED 11/18/69.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE 11/19/69
24c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery
24d. LOCATION (City, town, or county) (State) Odessa,Missouri

DATE REC'D BY LOCAL REG. Nov 20, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Paul D.Reynolds — LICENSE NO. E-495

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5413
Local Reg. No. D-388
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
NOV 25 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer, Idaho 83328
d. STREET ADDRESS (If rural, give location) 510 Main Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MILLIE		McMILIN	November 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	October 14, 1877	92		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Hickory County, Missouri	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Stukesbury	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	516 60 1446T	+ Mrs Floyd Tudor	Filer, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4360

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic nephritis and hypertension — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April 22, 1966, *to* November 14, 1969, *that I last saw the deceased alive on* November 10, 19 69, *and that death occurred at* 4:30 pm, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C W Cullings MD	Buhl, Idaho	11.15.69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11.17.69	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 20, 1969	Marva D. Marsh	Edgar J. Robertson	E-507

FIRM NAME White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5414
Local Reg. No. D 393
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 25 1969 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. View Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Hazelton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) CLEO b. (Middle) c. (Last) TRIVITT

4. DATE OF DEATH (Month) (Day) (Year) November 16, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH
9. AGE (In years last birthday) 49 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mt. Home, Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Trivitt BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Anna Ramsey BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.#2
16. SOCIAL SECURITY NO. 423-12-3271
17. INFORMANT'S OWN SIGNATURE Murtaugh, ADDRESS Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple sclerosis — 10 yrs +
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/3, 1966, *to* 11/16/, 1969, *that I last saw the deceased alive on* 11/15, 1969, *and that death occurred at* 12:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE James H. Bedford 459 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 11/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/19/69
24c. NAME OF CEMETERY OR CREMATORY Hazelton, Cemetery
24d. LOCATION (City, town, or county) Hazelton, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 24, 1969
REGISTRAR'S SIGNATURE Mona D. Marsh
25. EMBALMER James C. Reynolds
LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5415
Local Reg. No. D-397
Reg. Dist. No. 460

Certificate of Death

RECEIVED
NOV 28 1969
Bureau of Vital Stat.

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 14 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1856 Eldredge 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 1856 Eldredge

3. NAME OF DECEASED (Type or Print)
a. (First): EDWARD
b. (Middle): MAILON
c. (Last): GUEST, JR.

4. DATE OF DEATH (Month) (Day) (Year): November 18, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 10, 1909
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station Op. 26
10b. KIND OF BUSINESS OR INDUSTRY: Gasoline
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward M. Guest, Sr., BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Ada Cook, BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II 4
16. SOCIAL SECURITY NO.: 519-09-7450
17. INFORMANT'S OWN SIGNATURE: Twin Falls, Idaho — ADDRESS: Dorothy G. Guest

4100

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease with long standing anginal syndrome.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arterial Hypertension & obesity.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/23/ *, 19*53*, to* 11/18 *, 19*69*, that I last saw the deceased alive on* 11/14 *, 19*69*, and that death occurred at* 11:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Vaughn +22 M Ford
23b. ADDRESS: 1216 Filer Ave. East, Twin Falls, Idaho
23c. DATE SIGNED: 11/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Pk.
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 26, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: William J Boyd
LICENSE NO.: E-490

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 5416
Local Reg. No. D-398
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42 DEC 2 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
Bureau of Vital Statistics
LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 640 Filer Ave. West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PETER	HARRISON		Nov. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	April 28, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Custodian 06	Custodial	Italy	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNK	Italy	UNK	Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	518-07-2218	Dwight W Sullivan	Twin Falls,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Coronary Thrombosis	Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Cardiovascular Disease & enlargement	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pulmonary Emphysema & Chronic Bronchitis	12 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-10, 1949, *to* 11-20, 1969, *that I last saw the deceased alive on* 9-17, 1969 *and that death occurred at* 12:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
338 D.J. McClusky MD	Twin Falls Idaho	11-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 25, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 1 1969	Marie O. Marsh	Ronald J. Hamilton	E-470

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 2 - 1969

DEC 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5417
Local Reg. No. D-406
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
420 DEC 8 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Castleford
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Rural 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Castleford
d. STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print) a. (First) LOUIS b. (Middle) c. (Last) HOLDERREED

4. DATE OF DEATH (Month) (Day) (Year) Nov. 20, 1969

5. SEX male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 13, 1875

9. AGE (In years last birthday) 94
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Goshen [illegible], Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Holderreed
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Lucy Ann Rheinboldt
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-36-9424

17. INFORMANT'S OWN SIGNATURE * Frances L. Holderreed
ADDRESS Tucon, Ariz.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-7 , 1969 , *to* 11-20-69 , 19 , *that I last saw the deceased alive on* 11-16-69 , 19 , *and that death occurred at* 11:35p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] MD 118

23b. ADDRESS 122 9th Ave. No. Buhl

23c. DATE SIGNED 11-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 25, 1969

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. Dec 5, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER [signature]

LICENSE NO. E-516

FIRM NAME: White Mortuary Twin Falls, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5418
Local Reg. No. D-395
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
NOV 28 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hosp. 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 1632 11th Av. East

3. NAME OF DECEASED (Type or Print) a. (First) DAVID b. (Middle) E. c. (Last) FOX

4. DATE OF DEATH (Month) November (Day) 29 (Year) 1969

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 8, 1904

9. AGE (In years last birthday) 65
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Entomologist 21

10b. KIND OF BUSINESS OR INDUSTRY Entomology

11. BIRTHPLACE (State or foreign country) Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Irvin Bruce Fox
BIRTHPLACE UNK

14. MOTHER'S MAIDEN NAME Mary Woodard
BIRTHPLACE West Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-36-9099A

17. INFORMANT'S OWN SIGNATURE & Ellen E. Fox. ADDRESS Twin Falls, Id.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma Colon. c — INTERVAL BETWEEN ONSET AND DEATH 5 mo

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Metastases

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 7-9-69

19b. MAJOR FINDINGS OF OPERATION Carcinoma of colon with Metastases

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-9, 1969 to 11-21, 1969, that I last saw the deceased alive on 11-21, 1969, and that death occurred at 9:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE George W. Warner (Degree or title) MD

23b. ADDRESS 111 6th Ave E Twin Falls.

23c. DATE SIGNED 11-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/24/1969

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 26, 1969

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER Jerry D. Holman

LICENSE NO. E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 1969

DEC 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 8 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5419
Local Reg. No. D-396
Reg. Dist. No. 460

RECEIVED DEC 2 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 710 south 3rd street

3. NAME OF DECEASED (Type or Print)
a. (First) Albert
b. (Middle) Emanuel
c. (Last) Fetzer

4. DATE OF DEATH (Month) (Day) (Year) Nov 23 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb 20 1916
9. AGE (In years last birthday) 54 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) McPherson County-South Dakota
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Fetzer BIRTHPLACE South Russia
14. MOTHER'S MAIDEN NAME Matilda Ruff BIRTHPLACE South Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 567 20 8001
17. INFORMANT'S OWN SIGNATURE Mrs. Dorothea C Fetzer ADDRESS

18. CAUSE OF DEATH 1519
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the stomach — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with extensive metastasis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1969, *to* Nov 23, 1969, *that I last saw the deceased alive on* Nov 23, 1969, *and that death occurred at* 2:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Russell A Newcomb MD (Degree or title) 881
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 25 Nov 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11-23 89
24c. NAME OF CEMETERY OR CREMATORY HEYBURN CEMETERY
24d. LOCATION (City, town, or county) (State) HEYBURN Idaho

DATE REC'D BY LOCAL REG. 11-26-69
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER Robert C Walk
LICENSE NO. E 294

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WALK MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5420
Local Reg. No. D-374
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 28 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 TwinFalls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY TwinFalls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 2044 Sunrise Circle

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BENJIMAN	F.	WALTON	November 24,1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	September 17,1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor Builder	Construction	Rupert, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Parley P. Walton	UNK	Hazel Twitchell	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	530 09 1664	Mrs. Dean Walton	TwinFalls Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY Yes / No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August 1 ,1953, *to* November 24 ,19 69 , *that I last saw the deceased alive on* November 24 ,1969 , *and that death occurred at* 5:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean H Addleck MD	231 4th Avenue North Twin Falls, Idaho	11.25.69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11.26.69	Sunset Memorial Park Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 26, 1969	Marva D. Marsh	Jerry D. Holman	E-516

FIRM NAME: White Mortuary TwinFalls, Idaho

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 1969

JUL 24 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 19 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5421
Local Reg. No. D-402
Reg. Dist. No. 460

Certificate of Death

RECEIVED
DEC 4 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (If not in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 1890 2nd Ave. East

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): J.
c. (Last): HANCHEY

4. DATE OF DEATH (Month) (Day) (Year): Nov. 25, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov. 21, 1914
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): dealer & auto body
10b. KIND OF BUSINESS OR INDUSTRY: 22 automobile
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John William Hanchey — BIRTHPLACE: N.C.
14. MOTHER'S MAIDEN NAME: Mary Clifton Thomas — BIRTHPLACE: Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: 526-56-6604
17. INFORMANT'S OWN SIGNATURE: John Hardy — ADDRESS: Twin Falls, Ida.

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute infarction of the myocardium — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic coronary artery
DUE TO (c): Thrombosis. — 15 min

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Previous infarction of myocardium — 4 yrs ago.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 16 Sept, 1965, *to* 7 March 69, *that I last saw the deceased alive on* 7 March, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B.C. Kreilbamp M.D. 296
23b. ADDRESS: 676 Shoup Twin Falls Idaho
23c. DATE SIGNED: 11/28/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 11-29-69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 3 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: Dale P. Patterson
LICENSE NO.: E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5422
Local Reg. No. D-399
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
DEC 2 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Kimberly 83341
d. STREET ADDRESS (If rural, give location): Route # 2

3. NAME OF DECEASED (Type or Print)
a. (First): EMMA
b. (Middle): FRANCIS
c. (Last): COX

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 28, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 8, 1890

9. AGE (In years last birthday): 79
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Yakima Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hyrum F. Rock
BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Clara A. Bohman
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 519-20-2735

17. INFORMANT'S OWN SIGNATURE: X Read R Lyons
ADDRESS: Kimberly, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 792X Uremia
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Urinary retention
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes mellitus.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7/1/ , 19 69 , *to* 11/28/ , 19 69 , *that I last saw the deceased alive on* 11/25/ , 19 69 , *and that death occurred at* 5:50a m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 42V (Degree or title)

23b. ADDRESS: 1216 Filer Ave. East, Twin Falls, Idaho

23c. DATE SIGNED: 11/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: Dec. 1, 1969

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 1, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: Ronald D. Hamilton

LICENSE NO.: E-470

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 15 1970

JUL 28 1970

MAR 21 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5423
Local Reg. No. D-401
Reg. Dist. No. 460

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

DEC 4 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3 mi W. of T.Falls on Hiway 30 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: T.Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 1316 11th Avenue East

3. NAME OF DECEASED (Type or Print)
a. (First): LURA
b. (Middle): E.
c. (Last): TURNER

4. DATE OF DEATH (Month) (Day) (Year): November 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: October 19, 1894
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Manson, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Lee — BIRTHPLACE: Mason Co., Ky.
14. MOTHER'S MAIDEN NAME: Emma Brown — BIRTHPLACE: McLean, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-42-5962 B
17. INFORMANT'S OWN SIGNATURE: H. E. Turner — ADDRESS: Twin Falls, Idaho

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive chest trauma — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Auto Accident

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hi-way 30 - 3 mi. W. 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Twin Falls, Twin Falls, Idaho 13420

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11/29/1969/2 P.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Auto Accident

22. *I hereby certify that I attended the deceased from* Coroner's investigation only *19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 1:50 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Cloyce O. Edwards 583 4 (Degree or title): Coroner
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 12/1/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/2/69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 2, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: James C. Reynolds — James C. Reynolds
LICENSE NO.: E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 9 1988

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5424
Local Reg. No. D-408
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls (421)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital (143)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls (420)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) Lincoln Courts

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDNA	B.	HART	November 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	widowed	Febuary 21, 1881	88	9 / 9	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)		Weir City, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Porter	unknown	Mary Hudson	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-36-6849A	Everett Hart	Twinfalls Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

403X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CHRO. ARTERIOSCLEROSIS
DUE TO (c) GEN. ARTERIOSCLEROSIS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-28 19 69 *to* _____ 19____ *that I last saw the deceased alive on* 11-29 1969 *and that death occurred at* 6 10 a m. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
V. J. Stafford	525 MD	Twin Falls, Idaho	12/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 3, 1969	Buhl Cemetery	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 3, 1969	Marva D. Mash	George Farmer	E-480

FIRM NAME: Albertson-Dickard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5425
Local Reg. No. D-400
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls (421) DEC 4 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hospital (44)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding (240)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELIZABETH	ROBERTS	MOLDENHAUER	November 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	August 5, 1898	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)		Emporia, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Roberts	Wales	Mary Williams	Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-46-4244	Ed Moldenhauer	Filer, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 48 hr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-23, 1968, *to* 11/30/, 1969, *that I last saw the deceased alive on* 9-26, 1969, *and that death occurred at* 3:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward T Rees (431)	M.D.	Twin Falls, Idaho	12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12/3/69	Hagerman Cemetery	Hagerman, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 2, 1969	Marva A. Marsh	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5426
Local Reg. No. 21
Reg. Dist. No. 310

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY 430 Valley — DEC 9 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (In this place) 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Lakes Nursing Home 324

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho — b. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
IRL	C.	SHAW	November 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	October 10, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer - Carpenter 21		Smithfield, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clarence Shaw	Terre Haute, Indiana	Fanny Coonrod	Cherokee Co, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-01-8415	Yvonne Shaw	McCall, Ida

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular disease.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August, 19 69, *to* November 1, 19 69, *that I last saw the deceased alive on* November 1, 19 69 *and that death occurred at* 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
391 Ronald S. Mokes M.D.	McCall, Idaho	11-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 5, 1969	McCall, Cemetery	McCall, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 23-1969	Myrtle M. Gardner	Burton C. Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH--63021

AUG 7 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5427
Local Reg. No. 20
Reg. Dist. No. 318

BIRTH NO.

RECEIVED NOV 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley County Hospital 152

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
d. STREET ADDRESS (If rural, give location): General Delivery

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DORETHA	MARGUERITA	KOFOED	November 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Sept. 23, 1908	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Beautician 21		Alliance, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
T. A. Johnson	Nebraska	Betty Clara Johnson	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-07-1839	Lucy Kofoed	Cascade, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

150X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	CARCINOMA OF ESOPHAGUS	9 MTHS
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	CIRRHOSIS OF LIVER	5 YRS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		CASCADE VALLEY IDA

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* OCT. 19 67 *to* NOV 19 69 *, that I last saw the deceased alive on* NOV 5 *, 19* 69 *and that death occurred at* 7P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John J. Mozer 376 M.D.	CASCADE IDA	11/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 10, 1969	Margaret Cemetery	Cascade, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov-17-1969	Myrtle M Gardner	Burton C Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 8 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5428
Local Reg. No. 32
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
DEC 9 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (In this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
d. STREET ADDRESS (If rural, give location) Box 362

3. NAME OF DECEASED (Type or Print)
a. (First) FLORENCE
b. (Middle) MARIE
c. (Last) BANNON

4. DATE OF DEATH (Month) (Day) (Year) November 13, 1969

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 20, 1917

9. AGE (In years last birthday) 52
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY of

11. BIRTHPLACE (State or foreign country) Whitney, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME August Schmill
BIRTHPLACE Nebraska

14. MOTHER'S MAIDEN NAME Jennie Pearson
BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-03-6815

17. INFORMANT'S OWN SIGNATURE Harold F Bannon
ADDRESS Cascade, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypo Kalemia — 2 weeks
DUE TO (c) (1) Congestive heart failure (2) Azotemia — 2 years

II. OTHER SIGNIFICANT CONDITIONS (3) Hypertension. Due to Chronic glaucoma uncontrolled — 4 years
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ~~Nov 30-196~~
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-1-1965 *to* 11-13-1969 *, that I last saw the deceased alive on* 11-13-69 *, and that death occurred at* 11 45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Wayne F Allen 006 MD (Degree or title)
23b. ADDRESS McCall Idaho
23c. DATE SIGNED 11-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/17/69
24c. NAME OF CEMETERY OR CREMATORY Meadows Valley Cemetery
24d. LOCATION (City, town, or county) Meadows, (State) Idaho

DATE REC'D BY LOCAL REG. Nov-30-1969
REGISTRAR'S SIGNATURE Myrtle M Gardner
25. EMBALMER Burton E Walker
LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

OCT 19 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5429
Local Reg. No. 26
Reg. Dist. No. 320

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
NOV 6 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 907 E. Liberty

3. NAME OF DECEASED (Type or Print)
a. (First): Clara
b. (Middle): Agnes
c. (Last): Kiser

4. DATE OF DEATH (Month) (Day) (Year): 11 3 1969

5. SEX: female
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 8/13/1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Gresham, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jeremiah Barlow — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary Ellen White — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 519-01-8960
17. INFORMANT'S OWN SIGNATURE: Leonard F. Kiser — ADDRESS: Silverton, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute coronary occl — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosc. H.D. — 10 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Prog par alysis extrem — 3 yrs
Etiology undetermined

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/13, 69, *to* 11/3, 1969 *that I last saw the deceased alive on* 10/23, 1969, *and that death occurred at* 10:05 *P.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 186
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 11/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 11/5/69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser Washington Idaho

DATE REC'D BY LOCAL REG.: 11-3-69
REGISTRAR'S SIGNATURE: R. Dale Thomason
25. EMBALMER: R. Dale Thomason — LICENSE NO.: E 388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 11 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5430
Local Reg. No. 28
Reg. Dist. No. 320

RECEIVED
NOV 20 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN: Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 333
CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Oregon Slope

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ALICE	LOUISE	WEBER	Nov.	12	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Sept. 11, 1880	89	2	1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Georgetown, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alma Hayes	----	Annselina Hayes	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Grant Weber	Cambridge, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7963 Subject was confined to a nursing home and had been under a doctor's care. Her

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Doctor was out of town at the time of her death. There was no evidence of suspic-
DUE TO (c) ious or unusual circumstances. To the best of my knowledge and belief, subject

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. died of natural cuases.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Coroner's investigation, 19___, *to* ____, 19___, *that I last saw the deceased alive on* ____, 19___, *and that death occurred at* 2:10 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. Dale Thomason 583 4 Wash. Co. coroner	Weiser, Idaho	Nov.12,1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov.17,1969	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov.12,1969	L. Dale Thomason	L. Dale Thomason	E388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 29 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 29 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED DEC 3 1969 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 5431
Local Reg. No. 30
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitvale
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print)
a. (First): MARTIN
b. (Middle): LUTHER
c. (Last): SPEARS

4. DATE OF DEATH (Month) Nov. (Day) 14 (Year) 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Oct.31, 1900
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months 0, Days 12 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm & Railroad
11. BIRTHPLACE (State or foreign country): Ditt, Missouri
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Warren R. Spears — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Dessa Tomlinson — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-16-0301
17. INFORMANT'S OWN SIGNATURE: Leeta B. Hepp — ADDRESS: Council, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/09

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Sen arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/7, 1969, *to* 11/14, 1969, *that I last saw the deceased alive on* 11/7, 1969, *and that death occurred at* 2:50 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward Rewheeler M.D. 407
23b. ADDRESS: 14 East Idaho, Weiser, Idaho 83692
23c. DATE SIGNED: 11-14-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Bur. B
24b. DATE: Nov.18,1969
24c. NAME OF CEMETERY OR CREMATORY: Winkler Cemetery
24d. LOCATION (City, town, or county): Council — (State): Idaho

DATE REC'D BY LOCAL REG.: 11-14-69
REGISTRAR'S SIGNATURE: R. Dan Thomason
25. EMBALMER: Marshall S. Dickerson
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5432
Local Reg. No. 29
Reg. Dist. No. 320

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

NOV 25 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF TOWN
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Weiser Memorial Hosp. 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Baker 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LaGrande
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Howard
b. (Middle): --
c. (Last): Fester

4. DATE OF DEATH (Month) (Day) (Year): 11 15 1969

5. SEX: male
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH: 3/12/1905
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer 10
10b. KIND OF BUSINESS OR INDUSTRY: UPRR
11. BIRTHPLACE (State or foreign country): Gibbon, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fredrick Fester — BIRTHPLACE: ---
14. MOTHER'S MAIDEN NAME: Mary Webel — BIRTHPLACE: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ralph Fester by D. J. Thomason — ADDRESS: Kearney Neb.

7963

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subject was brought by ambulance to Weiser Memorial Hospital where he was pronounced dead. There was no evidence of suspicious or unusual circumstances. To the best of my knowledge and belief, he died of natural causes.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroner's investigation, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Dau Thomason 583 — Wash. Co. Coroner 4
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 11/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. 3
24b. DATE: 11/18/69
24c. NAME OF CEMETERY OR CREMATORY: Kearney Cemetery
24d. LOCATION (City, town, or county) (State): Kearney, Nebraska

DATE REC'D BY LOCAL REG.: 11-15-69
REGISTRAR'S SIGNATURE: R. Dau Thomason
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 2 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 9 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 6 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5433
Local Reg. No. 31
Reg. Dist. No. 320

RECEIVED DEC 3 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 440
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
LENGTH OF STAY (If this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rural Ranch 16 Mi. East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 440
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Amos
b. (Middle): Orlando
c. (Last): Tilford

4. DATE OF DEATH: (Month) 11 (Day) 22 (Year) 1969

5. SEX: male
6. COLOR OR RACE: daucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 6/29/1907
9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: ranching
11. BIRTHPLACE (State or foreign country): Weiser, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Tilford
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Eva I. Sawdon
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.: 519-03-7215
17. INFORMANT'S OWN SIGNATURE: Amos K. Tilford son. ADDRESS: 524 S. 5th St. Lakeview, Or.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Occlusive Coronary Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-24, 1969, *to* ____, 19__, ~~*that I last saw the deceased alive on* ____, 19__~~, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]
23b. ADDRESS
23c. DATE SIGNED: 11/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 11/28/69
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser Washington Idaho

DATE REC'D BY LOCAL REG.: 11-24-69
REGISTRAR'S SIGNATURE: T. Dale Thomson
25. EMBALMER: T. Dale Thomson
LICENSE NO.: E.388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 5 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5434
Local Reg. No. 32
Reg. Dist. No. 320

Certificate of Death

RECEIVED
DEC 8 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 441
a. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place) 26 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Weiser Mem. Hosp. 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 441
a. STATE Idaho
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 714 W. Galloway St.

3. NAME OF DECEASED (Type or Print)
a. (First) CLIFFORD
b. (Middle) LESLIE
c. (Last) ROBERTS

4. DATE OF DEATH (Month) (Day) (Year) Nov. 26, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug. 4, 1909
9. AGE (In years last birthday) 60 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retailer 22
10b. KIND OF BUSINESS OR INDUSTRY Merchant
11. BIRTHPLACE (State or foreign country) Thorton, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Yearb A. Roberts — BIRTHPLACE Tenn.
14. MOTHER'S MAIDEN NAME Myrtle M. Graham — BIRTHPLACE Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Yula Mae Roberts — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-24, 1968, *to* Nov. 26th, 1969, *that I last saw the deceased alive on* Nov. 25th, 1969, *and that death occurred at* 12:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE M. S. McGrath MD 344 (Degree or title)
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED 11-26-1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 11-29-69
24c. NAME OF CEMETERY OR CREMATORY Hillcrest
24d. LOCATION (City, town, or county) (State) Weiser, Idaho

DATE REC'D BY LOCAL REG. 11-29-69
REGISTRAR'S SIGNATURE R. Dale Thomason
25. EMBALMER Marshall S. Dickerson Jr.
LICENSE NO. E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5435
Local Reg. No. 961
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
JAN 20 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke's Hospital 022

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3120 Crescent Rim

3. NAME OF DECEASED (Type or Print): a. (First) SAMUEL b. (Middle) NMI c. (Last) BLOOM

4. DATE OF DEATH (Month) (Day) (Year): Oct 9, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 9, 1895

9. AGE (In years last birthday): 74
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Produce Buyer 24

10b. KIND OF BUSINESS OR INDUSTRY: Produce Industry

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 195 12 3275

17. INFORMANT'S OWN SIGNATURE: Elaine Bloom ADDRESS: 3120 Crescent Rim

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4121

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 wks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary artery disease — 10 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Hypertensive cardiovascular disease 10 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 July, 1965, *to* 9 Oct, 1969, *that I last saw the deceased alive on* 9 Oct, 1969, *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Clayton C Morgan 370 (Degree or title) M.D
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 10 Oct 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct. 10. 1969
24c. NAME OF CEMETERY OR CREMATORY: King David Cemetery
24d. LOCATION (City, town, or county) (State): Phil. Pa.

DATE REC'D BY LOCAL REG.: Jan. 16 1970
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 4 1970

AUG 10 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED JAN 7 1970 Bureau of Vital Statistics

State File No. 5436
Local Reg. No. 943
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Ada b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise LENGTH OF STAY (In this place): 17 Yrs. d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 915 Main Street	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise d. STREET ADDRESS (If rural, give location): 915 Main Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nick		Beloslutseff	11/29/69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never married	5/11/11	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Self employed	Produce sales	Russia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE	ADDRESS
No	572-14-4913	A.P.Dembowski-P.O.Box 7212, Boise	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7826

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis. — Brief.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Edema of Lower legs & Feet. — Months.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive *, 19____, that I last saw the deceased alive on ____ 19____ and that death occurred at 8A m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
C. E. Farris MD (Degree or title) Coroner	3720 Meadow Drive, Boise	12-15-69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/8/69	Joplin Cemetery	[illegible], Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 5 1970	Myrtle Palmer	Chadwick P. Dembowski	E-527

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Mountain View Funeral Home, Boi

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5437
Local Reg. No. 899
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna rural
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Dewey c. (Last) Reynolds

4. DATE OF DEATH (Month) (Day) (Year): Dec. 1, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 26, 1898

9. AGE (In years last birthday): 70
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Stone County, Missouri

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: James N. Reynolds
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Julia E. Book
BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-42-1955

17. INFORMANT'S OWN SIGNATURE: Alice Reynolds
ADDRESS: Kuna

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD — 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic myelogenous leukemia — 3 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [✓] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1966, 19__, to 30 Nov 69, 19__, that I last saw the deceased alive on 30 Nov 69, 19__, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE: Lee Hulley MD (Degree or title) 624

23b. ADDRESS: 925 E 15th Meridian

23c. DATE SIGNED: 12 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-4-69

24c. NAME OF CEMETERY OR CREMATORY: Kuna Cemetery

24d. LOCATION (City, town, or county) (State): Kuna, Idaho

DATE REC'D BY LOCAL REG.: Dec. 15 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Les Snead

LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5438
Local Reg. No. 891
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise — LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Center 332	d. STREET ADDRESS (If rural, give location) 2020 Amber St.

3. NAME OF DECEASED (Type or Print) a. (First) Matilda	b. (Middle) Bretine	c. (Last) Clary	4. DATE OF DEATH (Month) (Day) (Year) Dec. 2, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 17, 1891	9. AGE (In years last birthday) 78 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12	10b. KIND OF BUSINESS OR INDUSTRY Public Schools	11. BIRTHPLACE (State or foreign country) Yankton, So. Dakota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Brannon	BIRTHPLACE Norway	14. MOTHER'S MAIDEN NAME Ingeborg "Belle" Lee	BIRTHPLACE Norway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-46-6713	17. INFORMANT'S OWN SIGNATURE A. E. Alden	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4310

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Hemorrhage	10 da
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis & Hypertension	10 yr ±
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 11-14, 1967, *to* 12-2, 1969, *that I last saw the deceased alive on* 12-1, 1969, *and that death occurred at* 12:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE James S Hopkins Garner M.D. .242 (Degree or title)	23b. ADDRESS 4810 Fairview Suite #8	23c. DATE SIGNED 12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/4/1969	24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. Dec. 10 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Earl Waggoner	LICENSE NO. E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 0 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Matilda B. Clary

now lying buried in Syringa Gardens Cemetery, in the City or Town of Boise

County of Ada State of Idaho, who died on the 2 day of Dec., 1969, Aged 78 years 2 months

15 days, the cause of death being Cerebral hemorrhage, Arteriosclerosis & Hypertension and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

James L. Hoopingarner, M.D. attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Private Conveyance private or railway conveyance

to Mtn. View Mausoleum cemetery in the City or Town of Boise County of Ada

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Ada it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 5th day of March, A.D. 1974.

Permit issued to:
ALDEN-WAGGONER CHAPEL
5400 Fairview Ave.
Boise, Idaho 83704

Janet M. Wick
Director, Division of Vital Statistics
by Joyce B Foltz

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Boise State of Idaho, this 4th day of March, 1974.

[signature] MD
Health Officer

FORM BH 56-019

Certificate of Death
STATE OF IDAHO

State File No. 5439
Local Reg. No. 895
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 8 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7701 Ustick Rd. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 7701 Ustick Rd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROBERT	H.	CURRY	Dec. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 21, 1895	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printer 21	Printing	Dawes County, Neb.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Curry	Canada	Amanda Hess	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	505-01-6789	X Mrs. Edna B Curry	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12/12, 1961, to 12/2, 1969, *that I last saw the deceased alive on* 11/25, 1969, *and that death occurred at* 2:00 a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
095	M.D.	Boise, Idaho	12/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-4-69	Terrace Lawn Memorial Gardens	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 11 1969	Myrtle Palmer	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

OCT 21 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
DEC 9 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5440
Local Reg. No. 885
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 5½ Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convelecent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 725 Meridian St.

3. NAME OF DECEASED (Type or Print)
a. (First): Lester
b. (Middle): D.
c. (Last): Hunter

4. DATE OF DEATH (Month) (Day) (Year): Dec. 2, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 20, 1873
9. AGE (In years last birthday): 96
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supply Officer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Diamond Bluff, Wisc.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James D. Hunter
BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Martha Miro
BIRTHPLACE: Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-09-3899
17. INFORMANT'S OWN SIGNATURE: Ralph W. Hunter
ADDRESS: Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

486X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pneumonia
INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967, 19__, *to* present, 19__, *that I last saw the deceased alive on* 16 Nov, 1969 *and that death occurred at* 12:10A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 624 (Degree or title)
23b. ADDRESS: 925 E 1st Meridian
23c. DATE SIGNED: 8 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-5-69
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Dec. 9 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Jack H. Green
LICENSE NO.: 528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECORD Certificate of Death
STATE OF IDAHO

State File No. 5441
Local Reg. No. 160
Reg. Dist. No. 371

BIRTH NO.

DEC 9 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 24 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Sunset Nursing Home 335

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 106 East Jefferson Street

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE b. (Middle) HENRY c. (Last) PETERSEN

4. DATE OF DEATH (Month) (Day) (Year): Dec. 2, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 15, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer 08

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Petersen
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Eugenia Georgii
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-10-2880

17. INFORMANT'S OWN SIGNATURE: Bernice Petersen
ADDRESS: 106 E. Jefferson Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

595 X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardio-Vascular disease
DUE TO (c) Cystitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September, 1965, *to* December, 1969, *that I last saw the deceased alive on* Dec. 2, 1969, *and that death occurred at* 1:30 PM, *from the causes and on the date stated above.*

23a. SIGNATURE: E. L. Parkinson 407 (Degree or title)

23b. ADDRESS: 620 Hays Street,

23c. DATE SIGNED: 12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2

24b. DATE: 11-5-69

24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Crematory

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 9, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Harry A. Cowen

LICENSE NO.: E-526

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 2 9 1993 DEC 9 1969
DEC 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5442
Local Reg. No. 883
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION doa St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 419 North 9th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Franklin	Wilkerson	Dec. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 26, 1921	48		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Law enforcement officer and mortician 08		Twin Falls, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eugene B. Wilkerson	Kentucky	Mable A. Gormley	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 4	569-20-4816	X Lloyd L Wilkerson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov, 1966 *to* 12-2, 1969, *that I last saw the deceased alive on* 11-13, 1969, *and that death occurred at* 9 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W F Forney 173 MD	435 Bannock Boise	12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-6-1969	Syringa Gardens Cemetery, Boise, Idaho	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-8-69	Myrtle Palmer by Helen Olson	Alden Waggoner	E-422

Federal Security Agency
United States Public Health Service FORM PH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 8 - 1969

MAY 31 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5443
Local Reg. No. 881
Reg. Dist. No. 370

BIRTH NO.

DEC 5 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: 011 Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 4703 Kootenai

3. NAME OF DECEASED (Type or Print) a. (First): John	b. (Middle): B.R.	c. (Last): Lui	4. DATE OF DEATH (Month) 12 (Day) 3 (Year) 69	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced	8. DATE OF BIRTH: Sept 8, 1927	9. AGE (In years last birthday): 42 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker 21	10b. KIND OF BUSINESS OR INDUSTRY: Buttreys	11. BIRTHPLACE (State or foreign country): Chicago, Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Joseph Lui	BIRTHPLACE: Italy	14. MOTHER'S MAIDEN NAME: ~~Unknown~~ A. Bertolbi	BIRTHPLACE: Itlay	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Vet. WW"2 (If yes, give war or dates of service) 4	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Doris L. Lui	ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a): Acute Myocardial Infarction

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Coronary Artery Thrombosis (7 hrs.)

DUE TO (c): Coronary artery athero Sclerosis

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

Ventricular Aneurysm

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-23 1967 *to* 12-3 1969, *that I last saw the deceased alive on* 12-3 69, *and that death occurred at* 11:40 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Jim E. Cripps 094 (Degree or title)	23b. ADDRESS: 311 Idaho St	23c. DATE SIGNED: 12-5-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3	24b. DATE: Dec. 10 1969	24c. NAME OF CEMETERY OR CREMATORY: St. Joseph's	24d. LOCATION (City, town, or county) (State): Chicago, Ill.
DATE REC'D BY LOCAL REG.: Dec. 5 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Erle B. Byram	LICENSE NO.: E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 5 1969

DEC 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5444
Local Reg. No. 164
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 ADA DEC 16 1969

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY GOODING 240

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE Bureau of Vital Statistics

c. LENGTH OF STAY (In this place) 3 DAYS

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) HAGERMAN

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDAHO 004

d. STREET ADDRESS (If rural, give location) ROUTE # 1

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) H. c. (Last) PETERSON

4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 3, 1969

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED

8. DATE OF BIRTH MAY 17, 1893

9. AGE (In years last birthday) 76 IF UNDER 1 YR. Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 06

10b. KIND OF BUSINESS OR INDUSTRY GENERAL LABOR

11. BIRTHPLACE (State or foreign country) EVANSTON, WYOMING

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME GEORGE PETERSON BIRTHPLACE ST. CHARLES, NEW YORK

14. MOTHER'S MAIDEN NAME MARILYN ROBISON BIRTHPLACE ENGLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWI 3

16. SOCIAL SECURITY NO. 519-03-0365

17. INFORMANT'S OWN SIGNATURE James Bentley ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH 5603
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute flareup of chronic urinary tract infection (pyelonephritis) — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fecal impaction with rectal hemorrhage 3 days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized atherosclerosis — several years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. VA ~~I hereby certify that~~ attended the deceased from DECEMBER 1, 1969, to DECEMBER 3, 1969 ~~[illegible]~~, and that death occurred at 10:20a m., from the causes and on the date stated above.

23a. SIGNATURE O.G. RIML, M.D. 597 [signature] (Degree or title)

23b. ADDRESS VA CENTER, BOISE, IDAHO

23c. DATE SIGNED 12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE 12-6-1969

24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery

24d. LOCATION (City, town, or county) (State) Hagerman, Idaho

DATE REC'D BY LOCAL REG. Dec. 15 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Leonard C. Klahoff

LICENSE NO. E-481

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

MAR 1 4 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 6 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5445
Local Reg. No. 896
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 503	d. STREET ADDRESS (If rural, give location): 1502 Heron St.

3. NAME OF DECEASED (Type or Print) a. (First): EMMA	b. (Middle):	c. (Last): SCHIERDING	4. DATE OF DEATH (Month) (Day) (Year): Dec. 3, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: March 14, 1887	9. AGE (In years last birthday): 82 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Hannover, Germany	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Ernest Sack	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Dorothea Ehrenberg	BIRTHPLACE: Germany	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 534-20-4709	17. INFORMANT'S OWN SIGNATURE: X [signature]	ADDRESS	

18. CAUSE OF DEATH 4409
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	[illegible]	30 min
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Congestive Heart Failure	1 year
DUE TO (c)	Arteriosclerotic Vascular Disease	20 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/14/68, 19__, *to* 12/3/69, 19__, *that I last saw the deceased alive on* 12/3/69, 19__, *and that death occurred at* 4 30/4 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 516 (Degree or title)	23b. ADDRESS: 1703 Hill Road, Boise	23c. DATE SIGNED: 12/8/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12-5-69	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park	24d. LOCATION (City, town, or county): Boise, (State): Idaho
DATE REC'D BY LOCAL REG.: Dec. 11, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Gl W. Waters [signature]	LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 19 1969

MAY 24 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 28 1977
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5446
Local Reg. No. 165
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 90 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO
b. COUNTY CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CALDWELL
d. STREET ADDRESS (If rural, give location) 2219½ INDIANA AVENUE

3. NAME OF DECEASED (Type or Print) a. (First) SIDNEY b. (Middle) R. c. (Last) STUART

4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 3, 1969

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH JULY 12, 1891

9. AGE (In years last birthday) 78

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE BROKER

10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE

11. BIRTHPLACE (State or foreign country) COLFAX, WASHINGTON

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JACK STUART
BIRTHPLACE BANGOR, MAINE

14. MOTHER'S MAIDEN NAME LAURA REXFORD
BIRTHPLACE OREGON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES
(If yes, give war or dates of service) WWI 3

16. SOCIAL SECURITY NO. 518-16-5060

17. INFORMANT'S OWN SIGNATURE [signature]
ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2000

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Reticulum cell sarcoma.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
3 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

VA

22. I attended the deceased from SEPTEMBER 4, 1969, to DECEMBER 3, 1969, and that death occurred at 1:10 am from the causes and on the date stated above.

23a. SIGNATURE FRED B. HINE, M.D. [signature] (Degree or title) 597

23b. ADDRESS VA CENTER, BOISE, IDAHO

23c. DATE SIGNED 12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE 12-511969

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Gardens

24d. LOCATION (City, town, or county) near Nampa, (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 15 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER [signature]

LICENSE NO. E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 17 1969
DEC 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5447
Local Reg. No. 892
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: 423 S. 12th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 419 S. 12th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Theodore	J	Fields	Dec. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	July 14, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer --Kitchen	VA Hospital	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Paul Fields	Unknown	Beatrice E. Masteller	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 2 4	518-10-4999T	Earl Waggoner	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Probable coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: brief

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY--DID NOT SEE ALIVE *, 19__, to , 19__, that I last saw the deceased alive on , 19__, and that death occurred at 3 A m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Dr., Boise, Ida.	12/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/9/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 10, 1969	Myrtle Palmer	J. Udell Magee	E-390

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

2 c c.

DEC 31 1969

JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5448
Local Reg. No. 903
Reg. Dist. No. 370

BIRTH NO.

DEC 17 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ada County Nursing Home 300	d. STREET ADDRESS (If rural, give location) 1206 S. Owyhee St.

3. NAME OF DECEASED (Type or Print)	a. (First) Sidney	b. (Middle) L.	c. (Last) Nelson	4. DATE OF DEATH (Month) (Day) (Year) Dec. 4, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 15, 1896	9. AGE (In years last birthday) 73 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 21	10b. KIND OF BUSINESS OR INDUSTRY Painting	11. BIRTHPLACE (State or foreign country) Foston, Minn.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Nelson	BIRTHPLACE Sweden	14. MOTHER'S MAIDEN NAME Amanda Lind	BIRTHPLACE Sweden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-20-6638	17. INFORMANT'S OWN SIGNATURE Esther H. Nelson	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

582X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic nephritis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/12, 1969, *to* 12/4, 1969, *that I last saw the deceased alive on* 12/4, 1969, *and that death occurred at* 8 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 054 (Degree or title)	23b. ADDRESS [signature]	23c. DATE SIGNED 12/15/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-6-69	24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn Memorial	24d. LOCATION (City, town, or county) Boise, (State) Idaho
DATE REC'D BY LOCAL REG. Dec. 17, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER G. W. Waters [signature]	LICENSE NO. E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 17 1969
JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5449
Local Reg. No. 894
Reg. Dist. No. 390

BIRTH NO.

RECEIVED
DEC 1 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): four hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST LUKE'S HOSPITAL 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 3622 Jackie Lane

3. NAME OF DECEASED (Type or Print): a. (First) STEVEN b. (Middle) GLENN c. (Last) BARBOUR

4. DATE OF DEATH: (Month) DEC. (Day) 5 (Year) 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): NOT MARRIED

8. DATE OF BIRTH: Oct. 1, 1957

9. AGE (In years last birthday): 12
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT 05

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Pendelton, Oregon

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Glenn Albert Barbour, BIRTHPLACE: Eagle, Idaho

14. MOTHER'S MAIDEN NAME: Donna Allred, BIRTHPLACE: Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT'S OWN SIGNATURE: x Glenn Barbour, ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral & Brain stem Contusion — INTERVAL BETWEEN ONSET AND DEATH: 3hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/18, 1965, *to* 12-5, 1969, *that I last saw the deceased alive on* 12-5, 1969, *and that death occurred at* 10 10P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 318 (Degree or title): MD

23b. ADDRESS: 701 So Orchard Boise Ida

23c. DATE SIGNED: 12/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 10, 1969

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 11, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]

LICENSE NO.: E478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5450
Local Reg. No. 886
Reg. Dist. No. 370

BIRTH NO.

DEC 10 1969

Bureau of Vital

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 3 Wks	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 2004 N. 28th Street

3. NAME OF DECEASED (Type or Print) a. (First): CHARLES	b. (Middle):	c. (Last): THOMSON	4. DATE OF DEATH (Month) (Day) (Year): Dec. 5 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: July 22, 1880	9. AGE (In years last birthday): 89 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Rancher 04	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Aberdeenshire, Scotland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: James Thomson	BIRTHPLACE: Scotland	14. MOTHER'S MAIDEN NAME: Margaret Brown	BIRTHPLACE: Scotland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-28-7167	17. INFORMANT'S OWN SIGNATURE: Mary E Thomson	ADDRESS: 2004 N. 28th Boise	

4270

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Chronic Congestive Hr. Failure	15 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Uremia	6 months
DUE TO (c)	Senility	3 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1956, *to* 12-5, 1969, *that I last saw the deceased alive on* 12-5, 1969, *and that death occurred at* 3:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 319 (Degree or title)	23b. ADDRESS: Boise Idaho	23c. DATE SIGNED: 12-9-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Dec. 8, 1969	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery	24d. LOCATION (City, town, or county): Boise Ada (State): Idaho
DATE REC'D BY LOCAL REG.: Dec. 10, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Gary A. Cowger	LICENSE NO.: E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 9 1970
APR 28 1998

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics DEC 30 1969

State File No. 5451
Local Reg. No. 976
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada (011)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 8 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Nursing Home (320)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada (011)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1306 North 14th.

3. NAME OF DECEASED (Type or Print): a. (First) SARAH b. (Middle) VIOLET c. (Last) CAMPBELL

4. DATE OF DEATH (Month) (Day) (Year): Dec. 6, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec 6, 1888

9. AGE (In years last birthday): 81
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Franklin, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Morrison
BIRTHPLACE: No record

14. MOTHER'S MAIDEN NAME: Luey Ann Henson
BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 712-07-7257B

17. INFORMANT'S OWN SIGNATURE: Wanda Cowan
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1, 19 64, to Dec 6, 19 69, that I last saw the deceased alive on 12/6, 19 69, and that death occurred at 7:30 P m., from the causes and on the date stated above.

23a. SIGNATURE: Ray Conroy (054) (Degree or title) M.D.

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 12/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 11, 1969

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: Dec. 23, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant

LICENSE NO.: E 478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service FORM DH--63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 5 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5452
Local Reg. No. 893
Reg. Dist. No. 270

BIRTH NO.

RECEIVED DEC 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Antonio	Anton Gori	Arriola	12	7	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	Feb. 1, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheep 094	Sheep Industry	Mendarro, Spain	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jauquin Arriola	Spain	Josephine Yriondio	Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-12-2293A	X Pedro J. Arana	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Stroke

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebrovascular disease,
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/4, 1969, to 12/7, 1969, *that I last saw the deceased alive on* 12/7, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. Aberm 095, M.D.	Boise, Idaho	12/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-11-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 10 1969	Myrtle Palmer	Eric B. Bryan	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5453
Local Reg. No. 900
Reg. Dist. No. 370

BIRTH NO. RECEIVED

Informant, Funeral Director, Registrar and Medical Attendent. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Ada DEC 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau of Vital Statistics
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. STREET ADDRESS (If rural, give location) 714 E. 5th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	R.	Ernest	Dec. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Feb. 6, 1903	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
International Harvester Co.		Sioux Falls, So. Dajota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alfred Ernest	Iowa	Dora Nichols	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes W. W. 2	520-10-0164A	Millie Hall	Meridian, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Intra Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ?
DUE TO (c) ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pt. not seen prior to 12/5/69

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12/6/69	Cerebral Edema	Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/5/69, to 12/7/69, *that I last saw the deceased alive on* 12/7/69, *and that death occurred at* 12:45 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas D. Griffin 281	M.D.	616 Eastman Bldg.	12/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-11-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15 1969	Myrtle Palmer	Jack H. Grover	528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 15 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 10 1969 Bureau of Vital

State File No. 5454
Local Reg. No. 887
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — c. LENGTH OF STAY (In this place): 80 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 5417 Sites Dr.

3. NAME OF DECEASED (Type or Print)	a. (First) PALMER	b. (Middle) R.	c. (Last) IMBS	4. DATE OF DEATH (Month) Dec. (Day) 7 (Year) 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: July 20, 1918	9. AGE (In years last birthday): 51 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Manager 26	10b. KIND OF BUSINESS OR INDUSTRY: Culligan Water	11. BIRTHPLACE (State or foreign country): Stickney, South Dakota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Silas Imbs	BIRTHPLACE: -----	14. MOTHER'S MAIDEN NAME: Dorothy --	BIRTHPLACE: ------	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 505-01-0989	17. INFORMANT'S OWN SIGNATURE: Irene Imbs	ADDRESS: 5417 Sites Dr. Boise	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Colon Cancer — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 30, 1968, *to* Dec. 7, 1969, *that I last saw the deceased alive on* Dec 6, 1969, *and that death occurred at* 2:20a *m., from the causes and on the date stated above.*

23a. SIGNATURE: M M Rudolder, M.D. 071 (Degree or title)	23b. ADDRESS: 848 La Cassia, Boise	23c. DATE SIGNED: 12-9-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Dec. 10, 1969	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery	24d. LOCATION (City, town, or county): Boise Ada (State): Idaho
DATE REC'D BY LOCAL REG.: Dec. 10, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Howell D. Semaray	LICENSE NO.: E-509

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

6 -

DEC 10 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 16 1969 Bureau of Vital Statistics

State File No. 5455
Local Reg. No. 163
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 32 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 1711 FIRST STREET NORTH

3. NAME OF DECEASED (Type or Print): a. (First) PAULINO b. (Middle) R. c. (Last) LOPEZ

4. DATE OF DEATH (Month) (Day) (Year): DECEMBER 7, 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: JUNE 22, 1922

9. AGE (In years last birthday): 47
IF UNDER 1 YR. Months: -- Days: --
IF UNDER 24 HRS. Hours: -- Min.: --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER 04

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): KARNES CITY, TEXAS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LUCAN LOPEZ
BIRTHPLACE: TEXAS

14. MOTHER'S MAIDEN NAME: FRANCESCA RAMIRUZ
BIRTHPLACE: TEXAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WWII 4

16. SOCIAL SECURITY NO.: 452-28-5345

17. INFORMANT'S SIGNATURE: Lenore E. Bentley
ADDRESS: VA HOSPITAL RECORDS BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5719

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hepatic cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Uremia — 1 month
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from NOVEMBER 5, 19 69, to DECEMBER 7, 19 69 and that death occurred at 8:15p m., from the causes and on the date stated above.

23a. SIGNATURE: O. G. RIML, M.D. (Degree or title)

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: 12-10-69

24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Dec. 12 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: M. B. Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 16 1969

JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

OCT 13 1976

JAN 5 1978

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 10 1969
Bureau of Vital Statistics

State File No. 5456
Local Reg. No. 888
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 011 Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place) 1 Day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location) 209 Jantoni Drive

3. NAME OF DECEASED (Type or Print) a. (First) MILLARD	b. (Middle) GEORGE	c. (Last) SEXTY	4. DATE OF DEATH (Month) (Day) (Year) Dec. 7, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 20, 1903	9. AGE (In years last birthday) 66 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Mgr., Sexty's 22	10b. KIND OF BUSINESS OR INDUSTRY Jewelers	11. BIRTHPLACE (State or foreign country) Astoria, Oregon	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Sexty	BIRTHPLACE Nebraska	14. MOTHER'S MAIDEN NAME Ethel Pierce	BIRTHPLACE Oregon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO. 519-07-1635	17. INFORMANT'S OWN SIGNATURE Lois R. Sexty	ADDRESS 209 Jantoni Boise, Idaho

4339

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Infarction - Massive	10 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral Artery thrombosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Dec. 7, 1969, *to* _____, 19____, *that I last saw the deceased alive on* Dec 7, 1969, *and that death occurred at* 9:00 PM *from the causes and on the date stated above.*

23a. SIGNATURE C. C. Johnson 261 (Degree or title) MD	23b. ADDRESS Boise Idaho	23c. DATE SIGNED 12-9-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-10-69	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Dec. 10, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Norwell W. Demaray	LICENSE NO. E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

5

DEC 10 1969
AUG 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5457
Local Reg. No. 906
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 815 S. Curtis Rd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GUY		WOOD	Dec. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 8, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hiway Dept.	Idaho State	Speak Co., N. Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Wood	N. Y.	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-09-0857	X Mrs Guy Wood	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

887X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11-20-69	Sub Capital Fx Rt Hip	Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident	Fell down	Boise	Ada	Ida

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21f. HOW DID INJURY OCCUR?
Nov	18	69	? m.		Fell down

22. *I hereby certify that I attended the deceased from* 11/18/69, 19__, to 12/7/69, 19__, *that I last saw the deceased alive on* 12/7, 69, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. L. Daines M.D.	1015 N 8 Boise Ida	12-16

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	12-10-69	Cloverdale Memorial Park	Boise,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 17 1969	Myrtle Palmer	G. W. Waters	E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5458
Local Reg. No. 901
Reg. Dist. No. 870

BIRTH NO.

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1019 Longmont

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clarence	M.	Bales	12	8	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	Sept. 27, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 28		Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-10-6427A	X Maria I. Gebhards	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adenocarcinoma of the prostate — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypercalcemia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 20 August, 1969, *to* 8 December, 1969, *that I last saw the deceased alive on* 20 November, 1969, *and that death occurred at* 3:15p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Lyle Stones, M.D. 505 (Degree or title)	220 North 1st St., Boise, Ida.	12-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-10-69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 15, 1969	Myrtle Palmer	Lyle B. Byram	E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5459
Local Reg. No. 898
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (In this place) 13 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 825 East Jefferson St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DOROTHY	M.	KAUFMAN	Dec.	8	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	June 17, 1921	48		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tavern Owner 22	Same	Homedale, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Orr	Idaho	Mamie Tracy	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-18-1750	X Jack Kaufman	825 E. Jefferson Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

887X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Subdural Hematoma — INTERVAL BETWEEN ONSET AND DEATH: 12 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Trauma
DUE TO (c) Apparent fall at home

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
	C1	1-3C11

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ____, 1965, to Dec 8, 1969, that I last saw the deceased alive on Dec. 8, 1969, and that death occurred at 7:40p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Mark L. Bell, M.D. 039		Boise, Idaho	12/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1969	Morris Hill Cem.	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 12, 1969	Myrtle Palmer	Gary A. Cowger	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5460
Local Reg. No. 897
Reg. Dist. No. 370

BIRTH NO. RECEIVED DEC 12 1969 Bureau of Vital Statistics

375-4212

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise; c. LENGTH OF STAY (In this place) 3 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location) 315 N. 4th. Street

3. NAME OF DECEASED (Type or Print)	a. (First) Hilda	b. (Middle) Caroline	c. (Last) Cook	4. DATE OF DEATH (Month) (Day) (Year) Dec. 9, 1969		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 3/14/97	9. AGE (In years last birthday) 72	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12	10b. KIND OF BUSINESS OR INDUSTRY Public schools	11. BIRTHPLACE (State or foreign country) Owyhee Co. Idaho	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Walter T. Cook	BIRTHPLACE Missouri	14. MOTHER'S MAIDEN NAME Mary K. Johnston	BIRTHPLACE Arkansas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-14-4491	17. INFORMANT'S OWN SIGNATURE A.P. Dembowski	ADDRESS from mortuary info. A.P. Dembowski-Box 7212, Boise			

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

180X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 6, 1969, *to* _____, 19__, *that I last saw the deceased alive on* 12/9, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 654 (Degree or title)	23b. ADDRESS Res W Bannock	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment 4	24b. DATE 12/15/69	24c. NAME OF CEMETERY OR CREMATORY Mountain View Mausoleum	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. Dec. 12, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER [signature]	LICENSE NO. E-527

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Mountain View Funeral Home, Boise

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5461
Local Reg. No. 907
Reg. Dist. No. 370

BIRTH NO.

DEC 18 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place): 5½ months
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Peck	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convelesent Home 332	d. STREET ADDRESS (If rural, give location): General Delivery

3. NAME OF DECEASED (Type or Print) a. (First) William	b. (Middle) L.	c. (Last) Coomer		4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: March 5, 1902	9. AGE (In years last birthday): 67	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Planer 17	10b. KIND OF BUSINESS OR INDUSTRY: Lumber		11. BIRTHPLACE (State or foreign country): Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Dave Coomer	BIRTHPLACE: Kentucky		14. MOTHER'S MAIDEN NAME: Jane Tharp	BIRTHPLACE: Kentucky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 389-12-8795A		17. INFORMANT'S OWN SIGNATURE: Mrs. Dolores McKinney	ADDRESS: 6004 Overland Road Boise	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bilateral Bronchial Pneumonia - 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Severe Cerebral Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-23, 1969, *to* 12-10, 1969, *that I last saw the deceased alive on* 12-10, 1969 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 318	(Degree or title): MD	23b. ADDRESS: 401 So Orchard Boise Ida	23c. DATE SIGNED: 12/12/69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3	24b. DATE: Dec. 13, 1969	24c. NAME OF CEMETERY OR CREMATORY: Weisman Cemetery	24d. LOCATION (City, town, or county) (State): Clearwater Country Idaho
DATE REC'D BY LOCAL REG.: Dec. 17 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Gary A. Cowger	LICENSE NO.: E-526

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969
DEC 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5462
Local Reg. No. 902
Reg. Dist. No. 370

BIRTH NO.

DEC 18 1969

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place) 2 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalesant Center 332	d. STREET ADDRESS (If rural, give location) 9260 Sunflower Lane

3. NAME OF DECEASED (Type or Print) a. (First) MARGARET	b. (Middle) H.	c. (Last) PRUITT	4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 25, 1879	9. AGE (In years last birthday) 90 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Berryville, Arkansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Absalom Hawley	BIRTHPLACE Alabama	14. MOTHER'S MAIDEN NAME Rachel Philips	BIRTHPLACE Tenn.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-58-9643-T	17. INFORMANT'S OWN SIGNATURE Miss Lester Hendrickson	ADDRESS 9260 Sunflower Boise	

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arterio sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis — "
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* May, 1967, *to* 12-10, 1969, *that I last saw the deceased alive on* 12-10, 1969, *and that death occurred at* 10 *m., from the causes and on the date stated above.*

23a. SIGNATURE W. D. Forney 173 (Degree or title) M.D.	23b. ADDRESS 425 Bannock Boise	23c. DATE SIGNED 12-11-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-12-69	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park	24d. LOCATION (City, town, or county) Boise, (State) Idaho
DATE REC'D BY LOCAL REG. Dec. 16, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER G. W. Waters G W Waters	LICENSE NO. E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 17 1969
Bureau of Vital Statistics

State File No. 5463
Local Reg. No. 166
Reg. Dist. No. 171

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
LENGTH OF STAY (In this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) V. A. HOSPITAL, BOISE, IDAHO 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE OREGON 38
b. COUNTY GRANT 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CANYON CITY
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) LAWRENCE b. (Middle) H. c. (Last) ROBA

4. DATE OF DEATH (Month) DEC. (Day) 11 (Year) 1969

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH OCT. 7, 1905
9. AGE (In years last birthday) 64
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER 07
10b. KIND OF BUSINESS OR INDUSTRY SAME
11. BIRTHPLACE (State or foreign country) PAULINA, OREGON
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME GEORGE ROBA BIRTHPLACE AUSTRIA HUNGRY
14. MOTHER'S MAIDEN NAME MARY SOYJKA BIRTHPLACE AUSTRIA HUNGRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWII 4
16. SOCIAL SECURITY NO. 544 12 79 11
17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS V.A. HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1541

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic carcinoma, liver — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adenocarcinoma, rectum — 2 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12-30-68
19b. MAJOR FINDINGS OF OPERATION Abdominal perineal resection - nodes involved - no gross hepatic metastases at time of surgery.
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I attended the deceased from Dec. 5, 1969 to December 11, 19 69 and that death occurred at 3:05 p m., from the causes and on the date stated above.

23a. SIGNATURE Wm. W. Laxson W. W. LAXSON, M.D. (Degree or title) 547
23b. ADDRESS VAC, BOISE, IDAHO
23c. DATE SIGNED 12-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) 3
24b. DATE 12-13-69
24c. NAME OF CEMETERY OR CREMATORY Canyon City
24d. LOCATION (City, town, or county) (State) Canyon City, Oregon

DATE REC'D BY LOCAL REG. Dec. 17, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E 478
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 17 1969

MAR 3 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 28 1991

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 17 1969
Bureau of Vital Statistics

State File No. 5464
Local Reg. No. 904
Reg. Dist. No. 370
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 6½ Years
d. FULL NAME OF HOSPITAL OR INSTITUTION: At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2504 Grandee St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DAISY		HALL	DEC.	12	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 3, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Browntown, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel Howe — BIRTHPLACE: -----
14. MOTHER'S MAIDEN NAME: Lucinda Vanard — BIRTHPLACE: ------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-24-6267A
17. INFORMANT'S OWN SIGNATURE AND ADDRESS: 5725 Mtn View Drive, Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 4123 Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 12 yr
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 17, 1962, to Dec 12, 1969, *that I last saw the deceased alive on* Nov 13, 1969, *and that death occurred at* 6:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clayton C. Morgan 370	M.D	Boise Idaho	15 Dec 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 15, '69	Cloverdale Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 17 1969	Myrtle Palmer	Robert G. Ross	E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH–63021

DEC 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 5465
Local Reg. No. 905
Reg. Dist. No. 370

BIRTH NO.

DEC 17 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 35 Years

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1003 Vermont Avenue

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1003 Vermont Avenue

3. NAME OF DECEASED (Type or Print): a. (First) MYRTLE b. (Middle) G. c. (Last) NEDROW

4. DATE OF DEATH: (Month) Dec. (Day) 12, (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 25, 1895
9. AGE (In years last birthday): 74
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Norcatur, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: G. W. Farlow
BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Eva Weatherwax
BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-66-1035
17. INFORMANT'S OWN SIGNATURE: Marcelle M. Brewer ADDRESS: 2610 Davis, Boise, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Under Physicans care, and
Medication for Heart Condition. Months.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____ *and that death occurred at* 3:00 AM *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 12-15-69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-12-69
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 17 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Robert G. Ross
LICENSE NO.: E-497

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 17 1969
DEC 22 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5466
Local Reg. No. 167
Reg. Dist. No. 371

BIRTH NO.

RECEIVED DEC 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY BINGHAM 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BLACKFOOT
d. STREET ADDRESS (If rural, give location) 50 McADOO 83221

3. NAME OF DECEASED (Type or Print) a. (First) MARION b. (Middle) (nmi) c. (Last) SORENSEN

4. DATE OF DEATH (Month) DECEMBER (Day) 12 (Year) 1969

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH 2/26/95

9. AGE (In years last birthday) 74 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOL CUSTODIAN 06

10b. KIND OF BUSINESS OR INDUSTRY JANITOR

11. BIRTHPLACE (State or foreign country) CHESTERFIELD, IDAHO

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME NEIL SORENSEN BIRTHPLACE DENMARK

14. MOTHER'S MAIDEN NAME MARIE LARSEN BIRTHPLACE DENMARK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWI 3

16. SOCIAL SECURITY NO. 519 24 0622

17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute pulmonary embolism

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerotic heart disease with congestive heart failure.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Several weeks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from 12/11, 1969, to 12/12, 1969, and that death occurred at 2:05a m., from the causes and on the date stated above.

23a. SIGNATURE O. G. RIML, M. D. 597 [signature] (Degree or title)

23b. ADDRESS VA CENTER, BOISE, IDAHO

23c. DATE SIGNED 12/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify) 12-13-69 Removal

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY Shelley

24d. LOCATION (City, town, or county) Bingham (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 18, 1969

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Conway Grant

LICENSE NO. E478

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 30 1969 Bureau of Vital Statistics

State File No. 5467
Local Reg. No. 170
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: ADA	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: IDAHO b. COUNTY: PAYETTE 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE LENGTH OF STAY (In this place): 12 DAYS	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): PAYETTE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITAL, BOISE, IDAHO	d. STREET ADDRESS (If rural, give location): ROUTE #1, BOX 141-A

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MERRITT	KENNETH	SNOWBERGER	DECEMBER 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	MAY 8, 1900	69	— / —	— / —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER	FARMING	CARRINGTON, NORTH DAKOTA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
DAVID H. SNOWBERGER	INDIANA	ROSE HULTZ	INDIANA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WWI 3	543-03-9586A	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute myocardial infarction.	terminal
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease.	1963
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from DECEMBER 1, 1969, to DECEMBER 13, 1969 [illegible] and that death occurred at 6:15 AM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.G. STROMBERG, M.D. 597	VA CENTER, BOISE, IDAHO	12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12-13-69	Evergreen Cemetery	Ontario, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 23, 1969	Myrtle Palmer	[signature]	E-410

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 3 0 1969

JAN 5 1970
MAR 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 2 2 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5468
Local Reg. No. 957
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 13 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): Route # 1

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jess	H.	Hedges	12 - 14 - 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	April 3, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
retired farmer	same	Bower, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clement Hedges	Illinois	Eliza Ann Barnes	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-03-3248 A	Hazel L Hedges	Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 185X hyperkalemia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic renal failure — yrs
DUE TO (c) carcinoma of prostate — yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9 Dec 69, 19___, to death, 19___, that I last saw the deceased alive on 13 Dec 69, 19___ and that death occurred at ___m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lee L Culley MD	935 E 1st Meridian	15 D 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	12-16-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 12, 1970	Myrtle Palmer	Jack K. Green	E-528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false informatibn to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5469
Local Reg. No. 1168
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
DEC 23 1969

1. PLACE OF DEATH
a. COUNTY: ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 245 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: VALLEY 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): YELLOW PINE
d. STREET ADDRESS (If rural, give location): Box 11

3. NAME OF DECEASED (Type or Print): a. (First) THOMAS b. (Middle) M. c. (Last) HAGEN

4. DATE OF DEATH: (Month) (Day) (Year) December 16 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED

8. DATE OF BIRTH: 2/28/98

9. AGE (In years last birthday): 71
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINER 07

10b. KIND OF BUSINESS OR INDUSTRY: SAME

11. BIRTHPLACE (State or foreign country): BROOTIN, MINN.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMS HAGEN
BIRTHPLACE: NORWAY

14. MOTHER'S MAIDEN NAME: JULIA TOLLEFSON
BIRTHPLACE: NORWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WWII 4

16. SOCIAL SECURITY NO.: 540 05 4417

17. INFORMANT'S OWN SIGNATURE & ADDRESS: D. Morrison
VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Ureteral obstruction & chronic pyelonephritis — 3 months
DUE TO (c): Carcinoma, bladder — 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-9-65

19b. MAJOR FINDINGS OF OPERATION: Papillary carcinoma, bladder (resected. Tumor)

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from 4/15, 1969, to 12/16, 1969 and that death occurred at 9:35p m., from the causes and on the date stated above.

23a. SIGNATURE: Wm. W. Laxson (Degree or title)
W. W. LAXSON, M. D. 597

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 12/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-19-69

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 23, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer Lyon

25. EMBALMER: J. Udell Magee

LICENSE NO.: E- 390

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 23 1969

JAN 30 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5470
Local Reg. No. 909
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 22 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eagle Rural
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) E. c. (Last) Lockey Jr.

4. DATE OF DEATH (Month) (Day) (Year) Dec. 16, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 9, 1917
9. AGE (In years last birthday) 52 | IF UNDER 1 YR. Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Project Inspector 08
10b. KIND OF BUSINESS OR INDUSTRY Idaho Dept. of Highways
11. BIRTHPLACE (State or foreign country) Helena, Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John E. Lockey Sr. BIRTHPLACE IOWA
14. MOTHER'S MAIDEN NAME Minnie Anderson BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. 2 4
16. SOCIAL SECURITY NO. 517-09-2231
17. INFORMANT'S OWN SIGNATURE Caldwell John E. Lockey Jr. ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH 1½ yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION Oct. '68
19b. MAJOR FINDINGS OF OPERATION same
20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* early, 1965, *to* Dec. 16, 1969, *that I last saw the deceased alive on* Dec. 16, 1969, *and that death occurred at* 2:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE Robert Frazier M.D. 176 (Degree or title)
23b. ADDRESS Boise Idaho
23c. DATE SIGNED Dec. 18, 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-19-69
24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. Dec. 22, 1969
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Jack W. Green
LICENSE NO. 528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 22 1969

AUG 1 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 5471
Local Reg. No. 175
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA — JAN 5 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 43 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY ELMORE 209
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) MT. HOME
d. STREET ADDRESS (If rural, give location) Route A, Box 57

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VICTOR	J.	ACARREGUI	December 17 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	5/21/19	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RANCHER 04	SAME	JORDAN VALLEY, OREGON	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOHN ACARREGUI	SPAIN	PAULA AUCHUSTEGUI	SPAIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII	544 14 7987	Pat Moore	VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1519

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Peritonitis	12 hr.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Leak of bowel anastamosis	12 hr.
DUE TO (c)	Bowel obstruction due to recurrent carcinoma of stomach	4 wk.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12-4-69	Recurrent carcinoma of stomach with gastroduodenostomy obstruction.	Yes X No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.		

22. I, VA attended the deceased from 11/4, 1969, to 12/17, 1969, and that death occurred at 3:50a m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Wm. W. Laxson W. W. LAXSON, M. D. 547 (Degree or title)	VA CENTER, BOISE, IDAHO	12/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL 3	12-23-69	MTN. VIEW CEM.	MOUNTAIN HOME, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 2 1970	Myrtle Palmer	Allen Humphreys	E-502

FIRM NAME: SMITH MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 23 1970
JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5472
Local Reg. No. 917
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Eagle CDD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
d. STREET ADDRESS (If rural, give location): Eagle

3. NAME OF DECEASED (Type or Print): a. (First) MABEL b. (Middle) W c. (Last) KINKAID

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 17, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 27, 1898
9. AGE (In years last birthday): 71
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Buyer 26
10b. KIND OF BUSINESS OR INDUSTRY: Ladies Wear
11. BIRTHPLACE (State or foreign country): New Sharon, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Chauncey Wheeler BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: (Hattie) Harriett Mitchell BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-07-9942
17. INFORMANT'S OWN SIGNATURE: x Vera Wheeler (Chipman) ADDRESS

4121

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart Failure — Sudden

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension and Arteriosclerosis
DUE TO (c) Heart Disease 3yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 17, 1959 *to* Dec 17, 1969 *that I last saw the deceased alive on* Dec 17, 1969 *and that death occurred* 8 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] 088 (Degree or title)
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 12/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 12-20-69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Dec. 29 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Robert G. Rose
LICENSE NO.: E-497
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

[redacted] which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5473
Local Reg. No. 934
Reg. Dist. No. 370

Certificate of Death

RECEIVED
JAN 5 1970
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 115 Main

3. NAME OF DECEASED (Type or Print)
a. (First): FRANK
b. (Middle): WILLIAM
c. (Last): KUNNECKE

4. DATE OF DEATH (Month) (Day) (Year): December 17, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 12, 1898
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 25
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mountain Home, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: August Kunnecke — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Bertha Marie Schramm — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-09-3226
17. INFORMANT'S OWN SIGNATURE: Franklin O. Kunnecke — ADDRESS: Mt. Home, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19__, *to* —, 19__, *that I last saw the deceased alive on* 12-24-69, 19__, *and that death occurred at* 2:20 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 333
23b. ADDRESS: 808 LaCenia Dr Boise Idaho
23c. DATE SIGNED: 12/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 12/20/69
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Dec. 31 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Arthur Smith
LICENSE NO.: E-403

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Need 3 Cert Copies

Certificate of Death

STATE OF IDAHO

State File No. 5474
Local Reg. No. 908
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 19 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 902 North 18th

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 902 North 18 th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary		Rosandick	12	17	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	March 13, 1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Same	Kaniza Gospic, Yucoslavia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Milinkovich	Yucoslavia	Louise Kovacevic	Yucoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Mayed Rosandick	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary + Hypertensive heartdisease — 5yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1969, *to* death, 19____, *that I last saw the deceased alive on* 12-16, 1969, *and that death occurred at* 2-00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Boise Ida	12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-20-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19 1969	Myrtle Palmer	Eldon B. Gibson	E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 9 1969

AUG 2 8 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

State File No. 5475
Local Reg. No. 915
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 112 N. Garden 000	d. STREET ADDRESS (If rural, give location): 100 N. Garden

3. NAME OF DECEASED (Type or Print)	a. (First): Laura	b. (Middle): Belle	c. (Last): Schnell	4. DATE OF DEATH (Month) (Day) (Year): Dec. 17, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Jan. 25, 1880	9. AGE (In years last birthday): 89 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Fincastle, Tenn.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: John Henry Miller	BIRTHPLACE: Knoxville, Tenn.	14. MOTHER'S MAIDEN NAME: Frances M. Shepherd	BIRTHPLACE: Richmond, Va.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-44-5474	17. INFORMANT'S OWN SIGNATURE: Mrs. J. C. (Katharyn)	ADDRESS: Eddy	

4123

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary heart disease

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): arteriosclerotic heart disease.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/27, 1963, *to* 12/17, 1969, *that I last saw the deceased alive on* 11/17, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: C. Clohessy 095, M.D. (Degree or title)	23b. ADDRESS: Boise, Idaho	23c. DATE SIGNED: 12/19/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12/20/1969	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Dec. 26, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmerley	25. EMBALMER: A. E. Alden	LICENSE NO.: 299

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5476
Local Reg. No. 918
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY of Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 4405 Gage Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada or
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 4405 Gage Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HARLEY	DALE	TREMEWAN	Dec. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Dec. 14, 1935	34		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Invalid never worked 25		Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Sidney Tremewan	Elko, Nevada	Adelaide Tremewan	Silver City, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	None	X [signature]	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia, — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Anemia, — Unknown
DUE TO (c) Pneumococcic Meningitis & total mental deterioration. — 30 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Boise Ada	12-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-19-1969	Syringa Gardens	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Myrtle Palmer	Eldon T. Pearson	E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 10 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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5 Cert Copies

Certificate of Death
STATE OF IDAHO

State File No. 5477
Local Reg. No. 913
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 26 1969 Bureau of V.S.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 Weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 202 North Straughan

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes Hospital 002

3. NAME OF DECEASED (Type or Print): a. (First) Paul Francis; b. (Middle); c. (Last) Duffy

4. DATE OF DEATH: (Month) 12 (Day) 18 (Year) 69

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 28, 1903

9. AGE (In years last birthday): 66
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel B. Duffy
BIRTHPLACE: Philadelphia, Pa.

14. MOTHER'S MAIDEN NAME: Mary G. O'leary
BIRTHPLACE: Philadelphia, Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Mrs Paul F. Duffy
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: 2½ yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 12, 19 69 *to* Dec. 18, 19 69, *that I last saw the deceased alive on* Dec. 18, 19 69, *and that death occurred at* 7:15 p m. *from the causes and on the date stated above.*

23a. SIGNATURE: M M Rushlaubo, M.D. (Degree or title)

23b. ADDRESS: 848 La Cassia, Boise

23c. DATE SIGNED: 12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-22-69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 26, 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer by

25. EMBALMER: Eric B. Byram

LICENSE NO.: E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5478
Local Reg. No. 935
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
JAN 5 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 312 Ruby

3. NAME OF DECEASED (Type or Print)
a. (First): GOLDIE
b. (Middle): GERTRUDE
c. (Last): HIATT

4. DATE OF DEATH (Month) (Day) (Year): December 18, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Dec. 29, 1914

9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wendell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Adams
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Gertrude Handy
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-16-0851

17. INFORMANT'S OWN SIGNATURE: Warren J. Hiatt
ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerosis Obliterans — 5 yrs

DUE TO (c): Carotid & Vertebral Artery Stenosis — 6 mos.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-17-69

19b. MAJOR FINDINGS OF OPERATION: Severe Stenosis Right Carotid artery

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-3-, 19 69, *to* 12-18-, 19 69, *that I last saw the deceased alive on* 12-18-, 19 69, *and that death occurred at* 10:05 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Warren J. Hiatt M.D. 393
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 12-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/22/69
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Dec. 31, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Arthur Smith
LICENSE NO.: E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: JAN 27 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5479
Local Reg. No. 911
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 26 1969 Bureau of Vital Sta...

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332	d. STREET ADDRESS (If rural, give location): 808 N Curtis Rd.

3. NAME OF DECEASED (Type or Print) a. (First): Mary	b. (Middle): Ellen	c. (Last): Keizur	4. DATE OF DEATH (Month) 12	(Day) 18	(Year) 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Aug. 24 1889	9. AGE (In years last birthday): 80	IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone comp. 45 Years	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Pocatello, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME: Dennice Calahand	BIRTHPLACE: Ireland	14. MOTHER'S MAIDEN NAME: Johanna Hickey	BIRTHPLACE: Ireland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) n0 (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-07-2209	17. INFORMANT'S OWN SIGNATURE: Mrs Mary K Rudd	ADDRESS: Boise		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/28 *19*69*, to* 12/18 *, 19*69*, that I last saw the deceased alive on* 12/18 *, 19*69*, and that death occurred at* 1:40 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Md Sower MD 780 (Degree or title)	23b. ADDRESS: 312 Idaho	23c. DATE SIGNED: 12/19
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial; 24b. DATE: 12-22-69	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Dec. 26, 1969; REGISTRAR'S SIGNATURE: Myrtle Palmer by car	25. EMBALMER: Erle B. Byrum	LICENSE NO.: E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 29 1969
JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
AUG 2 0 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 12 1970
Bureau of Vital Statistics

State File No. 5480
Local Reg. No. 177
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place): 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE

d. FULL NAME OF HOSPITAL OR INSTITUTION: V.A.HOSPITAL,BOISE,IDAHO 004
d. STREET ADDRESS (If rural, give location): 319 FRANKLIN PARK DRIVE,BOISE

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ARCHIE	NMI	FARRIS	12	20	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	DIV.	2-19-02	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER 06	RETIRED	SPRINGDALE, ARK.	U.SA.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
WILLIAM FARRIS	TENN.	ROSA ROWLETT	ARK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII 4	540-32-64-39A	[signature]	V.A.HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pneumonia with pulmonary abscesses — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Residuals after cerebravascular accident 2 years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
VA m.		

22. ~~I hereby certify that~~ I attended the deceased from 12-15, 1969 to 12-20, 1969, ~~that I last saw the deceased alive~~ on ~~[illegible]~~, and that death occurred at 10:20a.m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
O.RIML,M.D. [signature] 591 (Degree or title)	VAC,BOISE,IDAHO	12-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec. 23, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 5, 1970	Myrtle Palmer	Bennett E. Spencer	E-395

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 27 1970
APR 24 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5481
Local Reg. No. 922
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place): 1 day
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): Rt. 1, Box 138

3. NAME OF DECEASED (Type or Print) a. (First): Michael	b. (Middle): Allen	c. (Last): Harsch	4. DATE OF DEATH (Month) (Day) (Year): Dec. 20, 1969	
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married	8. DATE OF BIRTH: Feb. 27, 1962	9. AGE (In years last birthday): 7 — IF UNDER 1 YR. Months 9 Days 23 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child 03	10b. KIND OF BUSINESS OR INDUSTRY: student	11. BIRTHPLACE (State or foreign country): Tillamook, Oregon	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William LeRoy Harsch	BIRTHPLACE: Riddle, Oregon	14. MOTHER'S MAIDEN NAME: Beverly Wilson	BIRTHPLACE: Lead, So. Dakota	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT'S OWN SIGNATURE: X William LeRoy Harsch	ADDRESS	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8121

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	1 Basal Skull fracture with massive cerebral injury	12 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. ~~DUE TO~~ (b)	2 - Ruptured Solid intra-peritoneal organ - Prob Liver with intra Peritoneal hemorrhage	12 hrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	3 - Fracture left Femur. 4 - Paralysis Respiratory Center	12 hrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION: no operation	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Highway 06	21c. (CITY, TOWN, OR TOWNSHIP) Emmett 13230 (COUNTY) Gem (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? Two car collision

22. *I hereby certify that I attended the deceased from* 7 Pm 12/30, 1969, *to* 12/30 11:30 Pm, 1969, *that I last saw the deceased alive on* 12/30, 1969, *and that death occurred at* 11:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. Jones MD. 267 (Degree or title)	23b. ADDRESS: Boise Idaho	23c. DATE SIGNED: 12/26/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): burial 3	24b. DATE: Dec. 23, 1969	24c. NAME OF CEMETERY OR CREMATORY: Emmett	24d. LOCATION (City, town, or county) (State): Emmett, Idaho
DATE REC'D BY LOCAL REG.: Dec. 30, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Glenn W Beatty	LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5482
Local Reg. No. 910
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 26 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38:206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3720 Meadow Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): #15 S. Roosevelt

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Emma	Ella	Lintelmann	Dec. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	1-7-1877	92		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Green Bay, Wisc.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Julius Teske	Germany	Anna	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-24-6358	Mildred E Paris	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Probable cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Renal Failure

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 4:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. Paris 583 4 Coroner	3720 Meadow Dr., Boise, Ida.	12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-22-69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 23, 1969	Myrtle Palmer Hyer	A. E. Alden	E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5483
Local Reg. No. 171
Reg. Dist. No. 371

BIRTH NO.

RECEIVED DEC 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place): 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): V.A. HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1415 W. State St. Boise, Id.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MILES	E.	OWENS	12-20-69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	10-23-92	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Restaurant Worker 22	Retired	Lobe City, Minn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
BARTON OWENS	Lobe City, Minn.	LAURA MITCHELL	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	519 20 09 08	Elmer Smith	V.A. HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

595X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Chronic nephrosis with uremia and	2 mo. +
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hemorrhagic cystitis	2 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Anemia, due to above diagnoses Chronic brain syndrome, arteriosclerotic	unknown 5 yrs.+

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from 12-3 19 69 to 12-20 19 69 that I last saw the deceased alive
, and that death occurred at 3:07p m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis, M.D. 597 ROBERT C. LEWIS, M.D.		VAC, BOISE, IDAHO	12-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/23/69	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 31, 1969	Myrtle Palmer	A. E. Alden	E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 31 1969

FEB 11 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5484
Local Reg. No. 179
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETS ADMIN HOSPITA, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): MERIDIAN
d. STREET ADDRESS (If rural, give location): 332 WEST IDAHO

3. NAME OF DECEASED (Type or Print): a. (First) HENRY; b. (Middle) CLAYTON; c. (Last) CARTER

4. DATE OF DEATH: (Month) DECEMBER (Day) 21, (Year) 1969

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED

8. DATE OF BIRTH: JUNE 29, 1915

9. AGE (In years last birthday): 54
IF UNDER 1 YR. Months: — Days: —
IF UNDER 24 HRS. Hours: — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 21: RADIO AND TV REPAIRMAN

10b. KIND OF BUSINESS OR INDUSTRY: RADIO & TV REPAIR

11. BIRTHPLACE (State or foreign country): MERIDIAN, IDAHO

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: HENRY C. CARTER
BIRTHPLACE: TEXAS

14. MOTHER'S MAIDEN NAME: ETTIE M. FLANNEY
BIRTHPLACE: MEXICO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): KOREAN CONFLICT

16. SOCIAL SECURITY NO.: 518-10-7753

17. INFORMANT'S OWN SIGNATURE: Lorraine Bentley
ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).
**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 2810 PERNICIOUS ANEMIA — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): INANITION, GENERAL, SECONDARY TO NO.1 — UNKNOWN
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from DECEMBER 20, 1969, to DECEMBER 21, 1969, and that death occurred at 4:40a m., from the causes and on the date stated above.

23a. SIGNATURE: Lyle T. Hooker
LYLE T. HOOKER, M.D. 597 (Degree or title)

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 12-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-24-69

24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery

24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Jan. 12, 1970

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Jack N. Green

LICENSE NO.: E-528

FIRM NAME: Robinson Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

DEC 30 1969

Bureau of Vital Statistics

State File No. 5485
Local Reg. No. 919
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 507 Logan

3. NAME OF DECEASED (Type or Print): a. (First) James; b. (Middle) E.; c. (Last) Miller

4. DATE OF DEATH (Month) (Day) (Year): Dec. 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Apr. 29, 1922

9. AGE (In years last birthday): 47
IF UNDER 1 YR. Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cattle Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Ranching

11. BIRTHPLACE (State or foreign country): Nampa, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Chris E. Miller
BIRTHPLACE: Minden, Nebraska

14. MOTHER'S MAIDEN NAME: Ethel Bumgarner
BIRTHPLACE: Blackfoot, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.2 4

16. SOCIAL SECURITY NO.: 519-16-1601

17. INFORMANT'S OWN SIGNATURE: x Mrs James E. Miller
ADDRESS: Boise Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1729

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Metastatic melanoma to brain — INTERVAL BETWEEN ONSET AND DEATH: 8 mo

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Malignant melanoma, skin
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec 6, 1969, *to* Dec 21, 1969, *that I last saw the deceased alive on* Dec 21, 1969, *and that death occurred at* 4:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ronald Koons 861 (Degree or title) M.D.

23b. ADDRESS: St Lukes Hospital

23c. DATE SIGNED: 12-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: 12/23/69

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Dec 29 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Richard W. Mesenbrink

LICENSE NO.: E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 3 0 1969
JAN 1 5 1970
JAN 2 7 1970
FEB 1 3 1970
FEB 3 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5486
Local Reg. No. 947
Reg. Dist. No. 370

Dr. Hein 425 W. Bannock

BIRTH NO.

RECEIVED
JAN 7 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 023

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Ida ho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1825 N. Maplegrove

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Inez	A.	Moon	12/21/69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	widowed	8/29/1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Kinney	Illinois	May Eubank	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-16-9193A	Ada R. Neighbaum	Boise, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pulmonary emphysema	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* 12/21/69, 19____ *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Matthew R. Hein 654 (Degree or title) M.D.	425 W Bannock	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/27/69	Terrace Lawn Gardens	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7 1970	Myrtle Palmer	Clyde J. Vassar	E-535

FIRM NAME: Cloverdale Funeral Home 375-2212

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38.206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

2

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5487
Local Reg. No. 172
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
JAN 5 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): BOISE
LENGTH OF STAY (In this place): 131 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: TWIN FALLS 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): FILER
d. STREET ADDRESS (If rural, give location): 616 HIGHWAY 30, % IDEAL MOTEL

3. NAME OF DECEASED (Type or Print): a. (First) JESSE; b. (Middle) EIMER; c. (Last) MORGAN
4. DATE OF DEATH (Month) (Day) (Year): DECEMBER 21, 1969

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: AUGUST 20, 1896
9. AGE (In years last birthday): 73
IF UNDER 1 YR. Months ___ Days ___ IF UNDER 24 HRS. Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MOTEL MANAGER 26
10b. KIND OF BUSINESS OR INDUSTRY: MOTEL
11. BIRTHPLACE (State or foreign country): CUMBERLAND, IOWA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM MORGAN
BIRTHPLACE: IOWA
14. MOTHER'S MAIDEN NAME: LAURA WORTHINGTON
BIRTHPLACE: IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WWI 3
16. SOCIAL SECURITY NO.: 529-26-0418
17. INFORMANT'S OWN SIGNATURE: Kenneth Bentley
ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): **Metastatic bronchogenic carcinoma** — INTERVAL BETWEEN ONSET AND DEATH: **1 Year**

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): **Bronchogenic carcinoma, left upper lobe.** — **2½ Years**
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: **Cerebro-vascular accidents, multiple**

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. VA attended the deceased from AUGUST 12, 1969, to DECEMBER 21, 1969, [illegible], and that death occurred at 4:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): R.J. BUNGARD, M.D. 597
23b. ADDRESS: VA CENTER, BOISE, IDAHO
23c. DATE SIGNED: 12-21-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12-21-69
24c. NAME OF CEMETERY OR CREMATORY: -----
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 31, 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E- 422
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended December 31, 1969

Certificate of Death
STATE OF IDAHO

State File No. 5488
Local Reg. No. 914
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Ada 01				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 01		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place): 31 days			b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise		
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002				d. STREET ADDRESS (If rural, give location): 3108 Barr Street		
3. NAME OF DECEASED (Type or Print) a. (First): Shirley	b. (Middle): Ann	c. (Last): Rawlins		4. DATE OF DEATH (Month) (Day) (Year): December 21, 1969		
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced	8. DATE OF BIRTH: May 28, 1929	9. AGE (In years last birthday): 40	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Clerk 25	10b. KIND OF BUSINESS OR INDUSTRY: Wholesale		11. BIRTHPLACE (State or foreign country): LaGrande, Oregon		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: W. B. Carpenter	BIRTHPLACE: Washington		14. MOTHER'S MAIDEN NAME: Georgette Myers		BIRTHPLACE: Ohio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: 519-22-5627		17. INFORMANT'S OWN SIGNATURE: William B. Rawlins	ADDRESS: 3108 Barr St., Boise, Ida		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7969

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pending autopsy report

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 19 49, *to* Dec 21, 19 69, *that I last saw the deceased alive on* Dec 21, 1969, *and that death occurred at* 10:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Max F. Bell, M.D. 039	Boise, Idaho	12-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Dec 24, 1969	Dry Creek	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-26-69	Myrtle Palmer	Robert G. Ross	E 497

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Summers Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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12-30-69

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed Dec. 26, 1969

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)

for Shirley Ann Rawlins (Name on Original Certificate) who died (Was Born or Died) on Dec. 21, 1969 (Date of Event)

in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 8 Date of Birth	June 28, 1929	May 28, 1929

Subscribed and sworn to before me this 31st day of December, 1969

Genevieve Greenwell

Notary Public, residing at Boise

My commission expires Sept 10, 1970

(Seal)

X Signed ..... (Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1217 North 20th Street

Boise, Idaho (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 31st day of December, 1969

Genevieve Greenwell

Notary Public, residing at Boise

My commission expires Sept 10, 1970

(Seal)

X Signed Robert G. Ross (Signature of Any Credible Person)

3724 Morris Hill Road

Boise, Idaho (Street Address, City, State)

FORM DH 60-155

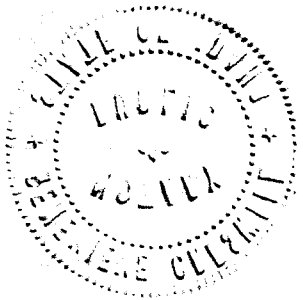

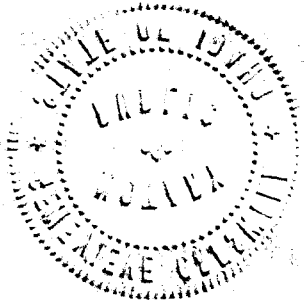

Certificate of Death

STATE OF IDAHO

State File No. 914
Local Reg. No. 370
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 26 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 31 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3108 Barr Street

3. NAME OF DECEASED (Type or Print): a. (First) Shirley; b. (Middle) Ann; c. (Last) Rawlins

4. DATE OF DEATH: (Month) Dec. (Day) 21, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: June 28, 1929

9. AGE (In years last birthday): 40
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Wholesale

11. BIRTHPLACE (State or foreign country): LaGrande, Oregon

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: W.B. Carpenter
BIRTHPLACE: Washington

14. MOTHER'S MAIDEN NAME: Georgette Myers
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-22-5627

17. INFORMANT'S OWN SIGNATURE: William B Rawlins
ADDRESS: 3108 Barr St. Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pending Autopsy Report

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June, 19 69, *to* Dec 21, 19 69, *that I last saw the deceased alive on* Dec 21, 19 69, *and that death occurred at* 10:30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Mark F Bell. (Degree or title): M.D
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek
24d. LOCATION (City, town, or county): Boise, (State): Idaho

DATE REC'D BY LOCAL REG.: 12-26-69
REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson
25. EMBALMER: Robert G. Ross
LICENSE NO.: E-497
FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service
FORM DH-63021

4—

DEC 29 1969

DEC 31 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5489
Local Reg. No. 924
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home 332	d. STREET ADDRESS (If rural, give location): 3313 Crescent Rim Dr.

3. NAME OF DECEASED (Type or Print) a. (First): Winifred	b. (Middle): C.	c. (Last): Rigney	4. DATE OF DEATH (Month) 12	(Day) 21	(Year) 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Feb. 7, 1891	9. AGE (In years last birthday): 78	IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): South Dakota	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: Elmer Frank Crow	BIRTHPLACE	14. MOTHER'S MAIDEN NAME: Emma Kurkenberger	BIRTHPLACE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-40-1512B	17. INFORMANT'S OWN SIGNATURE: x Wm H Rigney	ADDRESS		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 1951, 19__, *to* 12-21-69, 19__, *that I last saw the deceased alive on* 12-14-69, 19__, *and that death occurred at* 1:20 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Maurice M. Rubinfeld, M.D. 071 (Degree or title)	23b. ADDRESS: 848 La Cassia Reise	23c. DATE SIGNED: 12/23/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12/23/1969	24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Dec. 31 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: J. U. Magee	LICENSE NO.: E 390

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 31 1969

DEC 30 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 5490
Local Reg. No. 953
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 JAN 8 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 406 E. Jefferson St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	A. Crosby	Riley	Dec. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	March 11, 1877	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	New York	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Lawrence	New York	Emma Jean Beckwith	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No None	562-16-9106	Kathleen Crosby	406 E. Jefferson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 486X Pneumonia — 1

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebrovascular Insufficiency

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* Dec 21, 1969 *and that death occurred at* 4:15 PM *from the causes and on the date stated above.*

23a. SIGNATURE Myrtle Palmer 654 (Degree or title) M.D.
23b. ADDRESS 425 W Bannock
23c. DATE SIGNED 12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2
24b. DATE Dec. 23, 1969
24c. NAME OF CEMETERY OR CREMATORY Mountain View
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. Jan 7 1970
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Robert G. Ross
LICENSE NO. E-497
FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5491
Local Reg. No. 936
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location) 602 W. Washington St.

3. NAME OF DECEASED (Type or Print) a. (First) Audrey	b. (Middle) E.	c. (Last) Scott	4. DATE OF DEATH (Month) (Day) (Year) Dec. 21, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH April 6, 1902	9. AGE (In years last birthday) 67 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher 12	10b. KIND OF BUSINESS OR INDUSTRY public schools	11. BIRTHPLACE (State or foreign country) Tennessee	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Enlow	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Bertha M. Bradshaw	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-12-1991	17. INFORMANT'S OWN SIGNATURE Charles C. Enlow	ADDRESS	

18. CAUSE OF DEATH 5400
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute appendicitis c̄ perforation generalized peritonitis

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

19a. DATE OF OPERATION 12-20-69	19b. MAJOR FINDINGS OF OPERATION Perforated appendix c̄ generalized peritonitis	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-20-6, 1969, *to* 12-21-, 1969, *that I last saw the deceased alive on* 12-21-, 1969, *and that death occurred at* 5:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Glenn C. Gallup M.D. 530 (Degree or title)	23b. ADDRESS 125 E. Idaho	23c. DATE SIGNED 12/29/69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-26-69	24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) Boise	(State) Idaho	
DATE REC'D BY LOCAL REG. Dec. 31, 1969	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER Earl Waggoner
LICENSE NO. E-422		

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED Certificate of Death
STATE OF IDAHO

State File No. 5492
Local Reg. No. 931
Reg. Dist. No. 370
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital
on JAN 2 1970

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 300 South Straughan Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	S.	Campbell	Dec. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 25, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Insurance Executive 26	Insurance	Salt Lake City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert L. Campbell	Salt Lake, Utah	Laura J. Sanders	Salt Lake, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-07-7608	Esther F. Campbell	1211

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4/23

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: (?) several yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) coronary artery disease — (?) several yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-2 *,19*69*, to* 12-22 *,19*69*, that I last saw the deceased alive on* 12-22 *,19*69*, and that death occurred at* 8 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul T. Miner MD	1333 W. Jefferson St. Boise, Idaho	12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/27/1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 2, 1970	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: ALDEN-WAGGONER CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 2 1970

FEB 12 1971

MAR 2 9 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5493
Local Reg. No. 926
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2421 Joretta

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elvin	C.	Cummings	Dec 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	Married	Dec. 28, 1904	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
engineer 09	telephone	Spencer Co., Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph E. Cummings	Indiana	Anna Hearm	Spencer Co., Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-10-4634	X Ruth L Cummings	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ---- , 19___ , *to* Dec. 22, 1969 *only that I last saw the deceased alive on* 12/22 , 1969 , *and that death occurred at* 5:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	312 Idaho Boise	12/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3	Dec. 26, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 2, 1970	Myrtle Palmer	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 5 1970

MAY 1 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. MAR 8 1972
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5494
Local Reg. No. 920
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada OH
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 18 Jackson Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOE	K.	HATHAWAY	Dec.	22	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 11, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Driver-Maintenance 37	Pitman Oil Co.	Gary, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
McDory Hathaway	Indiana	Lillie May Kirk	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-07-0137A	Mildred I. Hathaway	18 Jackson Street Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary emphysema & fibrosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension and congestive Heart Failure.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6/30, 19 69, *to* 12/22, 19 69, *that I last saw the deceased alive on* 12/1, 19 69, *and that death occurred at* 4:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
095 M.D.	Boise, Ida	12/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 24, 1969	Cloverdale	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 30, 1969	Myrtle Palmer	O. Dale McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 30 1969

JAN 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 19 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5495
Local Reg. No. 173
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 010 JAN 5 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise (Rural) Bureau of Vital Statistics
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6 Miles E. near Interstate 80 200

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn. Home
d. STREET ADDRESS (If rural, give location): Rt. # 1, Box 611

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Richard
c. (Last): Pavel

4. DATE OF DEATH (Month) (Day) (Year): Dec. 22, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 7, 1933
9. AGE (In years last birthday): 36
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bank Manager 26
10b. KIND OF BUSINESS OR INDUSTRY: Financial
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph F. Pavel
BIRTHPLACE: Petersburg, Va.
14. MOTHER'S MAIDEN NAME: Sally Johnson
BIRTHPLACE: Conrad, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Korean 6
16. SOCIAL SECURITY NO.: 518-30-9169
17. INFORMANT'S OWN SIGNATURE: Mrs Norman L Johnson
ADDRESS: (Sally)

8414

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Traumatic head injuries
INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Crash of small airplane

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Rural 16.
21c. (CITY, TOWN, OR TOWNSHIP): Boise
(COUNTY): Ada 13010
(STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 22, 1969 m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Plane apparently iced up, causing it to crash

22. I hereby certify that I attended the deceased from AS CORONER ONLY-DID NOT SEE ALIVE, that I last saw the deceased alive on _____ 19__, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE: Frank E. Chalfan Jr. 583 4 (Degree or title) Justice of the Peace, Ada County Acting Coroner
23b. ADDRESS: Bank of Idaho Bldg. Boise, Idaho
23c. DATE SIGNED: 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 12/27/1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: Dec. 31 1969
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Earl Waggoner
LICENSE NO.: E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 26 1970
FEB 11 1970
FEB 18 1970
MAR 16 1970
JUL 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5496
Local Reg. No. 177
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 010 — JAN 5 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise (Rural)
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6 Miles E. near Interstate # 80 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn. Home
d. STREET ADDRESS (If rural, give location): Rt. # 1, Box 611

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Janis	Lynn	Pavel	Dec. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	March 10, 1934	35		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher 12	Public Schools	Coulee City, Wash.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel J. Jolly	Leahy, Wash.	Harriet Vaughn	N. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	533-30-1763	Dan Jolly	

8414

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Traumatic head injuries — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Crash of small airplane

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Rural 16	Boise 13010	Ada	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Dec. 22, 1969	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Plane apparently iced up, causing it to crash

22. *I hereby certify that I attended the deceased from* AS CORONER, ONLY — DID NOT SEE ALIVE *last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Attending or Coroner)	23b. ADDRESS	23c. DATE SIGNED
Harold E. Olson 53 Coroner Ada County	Bank of Idaho Bldg. Boise, Idaho	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/27/1969	Moscow Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 31, 1969	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: SMITH MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 11 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5497
Local Reg. No. 178
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
JAN 12 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 48 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETS ADMIN. HOSPITAL, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO
b. COUNTY CANYON 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CALDWELL
d. STREET ADDRESS (If rural, give location) 1122 DENVER STREET

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GERALD	CHARLES	SCHIMMELS	DECEMBER 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED	12-12-1915	54	— / —	— / —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 26	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SERVICE STATION OPERATOR	SAME	REPUBLICAN CITY, NEBR.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
TONEY SCHIMMELS	NEBRASKA	JOSIE HAYS	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWII 4	709-07-7783	James Bentley	VA HOSPITAL RECORDS, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bronchogenic carcinoma	1 year
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cachexia	1/2 year
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. VA attended the deceased from NOVEMBER 5, 1969, to DECEMBER 22, 1969, and that death occurred at 6:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O.G. RIML, M.D. 591	VA CENTER, BOISE, IDAHO	12-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec. 29, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 9, 1970	Myrtle Palmer	Kenneth E. Spence	E-395

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 13 1970
JAN 14 1970
MAR 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 30 1969 Bureau of Vital Statistics

State File No. 5498
Local Reg. No. 921
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 1 Year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 1112 O'farrell

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1112 O'farrell St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SELMA	E.	BOLLAR	Dec. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Aug. 14, 1910	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager 26	Dept. Store	Roseberry, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sam Nisula	Finland	Anna Humaki	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-32-4944	x Arthur J. Bollar	Rt. 1 McCall, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ruptured cerebral aneurysm
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4309

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 6.21, 1969, to 12.23., 1969, that I last saw the deceased alive on 6.24, 1969, and that death occurred at 3:00a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. F. Neuenschwander 387 M.D.	512 N. 16 St., Boise, Idaho	12.29.69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 27, '69	Cloverdale	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 30 1969	Myrtle Palmer	Norvell Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 30 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5499
Local Reg. No. 925
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 22 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Nursing 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1016 Eastman

3. NAME OF DECEASED (Type or Print): a. (First) Frances b. (Middle) Belle c. (Last) Ploeger

4. DATE OF DEATH: (Month) Dec. (Day) 23, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Sept. 11, 1881

9. AGE (In years last birthday): 88
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Peru, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William J. Richardson
BIRTHPLACE: Pa.

14. MOTHER'S MAIDEN NAME: Sarah E. Tevebaugh
BIRTHPLACE: Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-54-5240

17. INFORMANT'S OWN SIGNATURE: Joseph A. Ploeger
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4442

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Small bowel obstruction e infarction — 13 days

19a. DATE OF OPERATION: 12-10-69.

19b. MAJOR FINDINGS OF OPERATION: Infarction small bowel

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-10- , 1969, to 12-23- , 1969, that I last saw the deceased alive on 12-22- , 1969, and that death occurred at 5A m., from the causes and on the date stated above.

23a. SIGNATURE: Glenn E. Allen MD (Degree or title)

23b. ADDRESS: 125 E. Idaho

23c. DATE SIGNED: 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-27-69

24c. NAME OF CEMETERY OR CREMATORY: Emmett Cemetery

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Dec. 31 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: O. E. Alden

LICENSE NO.: E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 31 1969

NOV 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5500
Local Reg. No. 923
Reg. Dist. No. 370

69-11789
BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011 JAN 2 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 603

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1132 East Bannock St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	CHARLES	ZUNIGA	Dec.	23	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Nov. 6, 1969		1	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---- 07
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Raul Zuniga	California	Mary Bangi	California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ------
17. INFORMANT'S OWN SIGNATURE 1132 E. Bannock ADDRESS St. X Mary Zuniga Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7969

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Sudden Death Syndrome ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Birth, 19__, to Dec 8, 19 69, that I last saw the deceased alive on 12 8, 19 69 and that death occurred at 7 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
519 [illegible] MD	200 E Bannock St Boise	12-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Dec. 26, 1969	Terace Lawn Cemetery	Boise	Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 30 1969	Myrtle Palmer	[illegible]	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5501
Local Reg. No. 956
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
JAN 12 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST ALPHONSUS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 811 EAST BANNOCK

3. NAME OF DECEASED (Type or Print): a. (First) HENRY b. (Middle) O. c. (Last) MACK

4. DATE OF DEATH (Month) (Day) (Year): December 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 17, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Hailey, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
W. S. Mack	Wisconsin	Margaret C. O'Bryan	California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-07-7616A
17. INFORMANT'S OWN SIGNATURE: Jessie C. Mack ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Ruptured (R) iliac aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Aortitis — 20 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from August, 1941, to Dec 24, 1969, that I last saw the deceased alive on Dec 23, 1969, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Boise Idaho	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-27-1969	Morris Hill Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 9 1970	Myrtle Palmer	Elden T. Pearson	E-512

Federal Security Agency
United States Public Health Service FORM GH-63021

FIRM NAME: Relyea Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics
JAN 5 1970

State File No. 5502
Local Reg. No. 938
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (In this place): 4 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home -- 2504 Grandee St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2504 Grandee

3. NAME OF DECEASED (Type or Print): a. (First) EVA; b. (Middle) L.; c. (Last) SHEETS

4. DATE OF DEATH: (Month) Dec. (Day) 24 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 10, 1879

9. AGE (In years last birthday): 90
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Union, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John R. Haynes
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 519-60-0010

17. INFORMANT'S OWN SIGNATURE: Eva Sheets
ADDRESS: 5201 Chinden Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 4369 CVA — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 11:30p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: R Bruce Moody M.D. (Degree or title) 368
23b. ADDRESS:
23c. DATE SIGNED: 12/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 30, '69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Jan 2 1970
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Harry A. Sowers
LICENSE NO.: E-526
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Ward, 2913 Overland

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5503
Local Reg. No. 169
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Washington CO. 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — LENGTH OF STAY (In this place): 3 Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Nursing Home 235	d. STREET ADDRESS (If rural, give location): 428 East Main

3. NAME OF DECEASED (Type or Print)	a. (First) Mabel	b. (Middle) Cope	c. (Last) Smith	4. DATE OF DEATH (Month) 12 (Day) 24 (Year) 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Oct, 14, 1885	9. AGE (In years last birthday): 84 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Weiser, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-14-7033	17. INFORMANT'S OWN SIGNATURE: Don J. McClenahan	ADDRESS:	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

582X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Uremia	1 week
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Chronic nephritis	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1st, 1967, *to* Dec 24, 1969, *that I last saw the deceased alive on* Dec 24, 1969, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Roscoe C. Ward MD (Degree or title) 550	23b. ADDRESS: Boise Idaho	23c. DATE SIGNED: Dec 26 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3	24b. DATE: 12-27-69	24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery	24d. LOCATION (City, town, or county) (State): Weiser, Idaho
DATE REC'D BY LOCAL REG.: Dec. 26, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer by Carl	25. EMBALMER: Erle B. Byram	LICENSE NO.: E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5504
Local Reg. No. 927
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 40 Mesa Vista

3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH b. (Middle) M. c. (Last) ELMER
4. DATE OF DEATH (Month) (Day) (Year) Dec. 25, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH July 10, 1886
9. AGE (In years last birthday) 83
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) New Castle, England
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME McKay Cubby BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Emily Lewis BIRTHPLACE England
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 519-40-1486
17. INFORMANT'S OWN SIGNATURE John H. Elmer ADDRESS 1111 E. Boise Ave Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
4109
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Atherosclerosis
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus, Generalized Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [x] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-20, 1969, to 12-25, 1969, that I last saw the deceased alive on 12-24, 1969, and that death occurred at 6:55 AM from the causes and on the date stated above.

23a. SIGNATURE C. E. Johnson, M.D. (Degree or title)
23b. ADDRESS Boise Ida
23c. DATE SIGNED 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-29-69
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. Jan. 2, 1970
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Robert G. Lee
LICENSE NO. E-497
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 - 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5505
Local Reg. No. 944
Reg. Dist. No. 270

BIRTH NO.

RECEIVED Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada JAN 7 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: 419 S. 14th St., Apt. 8

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 419 S. 14th St., Apt. 8

3. NAME OF DECEASED (Type or Print): a. (First) Calvin; b. (Middle) P.; c. (Last) Holmes

4. DATE OF DEATH (Month) (Day) (Year): Dec. 25, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Nov. 3, 1899

9. AGE (In years last birthday): 71
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: General labor

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Holmes
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Lucy Alice Brassfield
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-12-1827

17. INFORMANT'S OWN SIGNATURE: J. U. Magee
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY-DID NOT SEE ALIVE *, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) Coroner

23b. ADDRESS: 3720 Meadow Dr Boise

23c. DATE SIGNED: 1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/31/69

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens Cem.

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Jan. 5 1970

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Earl Waggoner

LICENSE NO.: E-422

FIRM NAME: Alden Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5506
Local Reg. No. 955
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01 — JAN 9 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY IN THIS PLACE: 7 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION: 707 Braemere Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 707 Braemere Road

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	W.	JOSLYN	Dec. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 21, 1916	53		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lithographer 21	Same	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Carroll W. Joslyn	Vermont	Grace Louise McLaughlin	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW II 4	548-26-1438	Grace A Joslyn	707 Braemere Boise, Idaho

4290

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiomegaly - since — INTERVAL BETWEEN ONSET AND DEATH: June '66

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Congestive Heart
DUE TO (c) failure beginning May '67

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Allergies & Asthma.

19a. DATE OF OPERATION	19b. ~~MAJOR FINDINGS OF OPERATION~~	20. AUTOPSY?
	no coronary artery disease.	Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* [illegible], 1962, *to* Dec. 25, 1969, *that I last saw the deceased alive on* Dec. 2, 1969, *and that death occurred at* 11:50 m., PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Francis M.D.	Boise Idaho	Jan. 9, 1970

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-29-69	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 9 1970	Myrtle Palmer	Gary A. Courger	E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. _____
Local Reg. No. 928
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 7 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 707 Braemere Road

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 707 Braemere Road

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) W. c. (Last) JOSLYN

4. DATE OF DEATH: (Month) Dec. (Day) 25, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 21, 1916

9. AGE (In years last birthday): 53
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lithographer

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carroll W. Joslyn — BIRTHPLACE: Vermont

14. MOTHER'S MAIDEN NAME: Grace Louise McLaughlin — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 548-26-1438

17. INFORMANT'S OWN SIGNATURE: Grace A Joslyn — ADDRESS: 707 Braemere Rd. Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cardiomegaly — INTERVAL BETWEEN ONSET AND DEATH: 8 yr.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): unknown cause
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Probably Myocardial infarction recent

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour):

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 —, 19 62 *to* Dec. 25, 19 69, *that I last saw the deceased alive on* Dec. 21, 19 69, *and that death occurred at* 11:50 m., PM *from the causes and on the date stated above.*

23a. SIGNATURE: Robert M. Draper, (Degree or title) M.D.

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: Dec. 30, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-29-69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Jan. 2 1970

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Gary A. Coerper

LICENSE NO.: E-526

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

~~JAN 2 1969~~
JAN 2 - 1970

AUG 2 0 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 17 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 28 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

MAR 29 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

SEP 30 1975

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

JUL 11 2014

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Clifford 311 Idaho

Certificate of Death

STATE OF IDAHO

RECEIVED

BIRTH NO.

* State File No. 5507
Local Reg. No. 937
Reg. Dist. No. 370

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
JAN 5 1970
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 22 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. FULL NAME OF HOSPITAL OR INSTITUTION: Saint Alphonsus Hospital 003
d. STREET ADDRESS (If rural, give location): 802 North 6th

3. NAME OF DECEASED (Type or Print)
a. (First) Antonio b. (Middle) c. (Last) Martiartu

4. DATE OF DEATH (Month) (Day) (Year): 12-25-69

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct-26, 1898

9. AGE (In years last birthday): 71
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheep Business 04

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Spain

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Francisco Martiartu
BIRTHPLACE: Spain

14. MOTHER'S MAIDEN NAME: Sotera Churruca
BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-54-1602

17. INFORMANT'S OWN SIGNATURE: * Mrs. Mary A. Martiartu
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) 1. Chronic Severe Obstructive

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Emphysema
DUE TO (c) (2.) Chronic Bronchitis & Pulmonary Fibrosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
(3.) Polycythemia See to (1)

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1965, 19____, *to* 12-25, 19 69, *that I last saw the deceased alive on* 12-24, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Joe E Gibson 094 (Degree or title)

23b. ADDRESS 311 Idaho Boise

23c. DATE SIGNED 12-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-29-69

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 31 1969

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eric B. Byram Joe E Gibson

LICENSE NO.: E-533

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Gibson Funeral Home

SEP 2 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5508
Local Reg. No. 940
Reg. Dist. No. 370

BIRTH NO.

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: ADA 001 — JAN 6 1970

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE Bureau of V

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RESIDENCE 1720 VISTA 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: IDAHO — b. COUNTY: ADA 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE

d. STREET ADDRESS (If rural, give location): 1720 VISTA

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	P.	MUTH	Dec. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	WIDOWED	June 20 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Restaurateur 22	Restaurant	Hustisford, Wisconsin	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Muth	Germany	Emma	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Lillian C. Malehorn	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Not Diagnosed

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Probable Arterio Sclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edgar D. Paris 583 + Coroner	3720 Meadow Dr.	1-3-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	December 29, 1969	Dry Creek	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 6, 1970	Myrtle Palmer	Conway Stuart	E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH–63021

JAN 6 - 1970
JAN 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5509
Local Reg. No. 962
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 20 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1509 So. Arcadia

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Mountain Home
d. STREET ADDRESS (If rural, give location): 15 miles SE Mtn. Home Ranch

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	HENRY	O'DANIEL	Dec. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	Oct. 17, 1899	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cattle Rancher
10b. KIND OF BUSINESS OR INDUSTRY: Livestock
11. BIRTHPLACE (State or foreign country): Rocky Bar, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME — BIRTHPLACE
14. MOTHER'S MAIDEN NAME — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-34-1533
17. INFORMANT'S OWN SIGNATURE: Mrs. Arthur C. Fellers ADDRESS: Bellevue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Carcinoma of Prostate, Arteriosclerotic Heart Disease

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-23, 1959, *to* 12-25, 1969, *that I last saw the deceased alive on* 12-23, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George R. Baker	MD	121 E. Idaho Boise	1-14-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/29/69	Mtn. View Cemetery	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 16, 1970	Myrtle Palmer	Arthur Smith	E-403

FIRM NAME: Smith Mortury

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Hair

425 W Barnard 16

Certificate of Death
STATE OF IDAHO

State File No. 5510
Local Reg. No. 913
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): ½ Month	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Garden City
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 4325 Chinden Blvd.

3. NAME OF DECEASED (Type or Print)	a. (First): Wilson	b. (Middle): Harvey	c. (Last): Pleasant	4. DATE OF DEATH (Month) (Day) (Year): 12-25-1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Oct. 18, 1915	9. AGE (In years last birthday): 52 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy Equipment Oper. 21	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Columbia S.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Green Pleasant	BIRTHPLACE: Columbia S.C.	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 250-10-3486	17. INFORMANT'S OWN SIGNATURE: Mrs. Wilson Pleasant	ADDRESS:	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive Heart Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on* 12/25, 1969, *and that death occurred at* 2:45 Am *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 654 (Degree or title)	23b. ADDRESS: 425 W Barnard	23c. DATE SIGNED: 12/26	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3	24b. DATE: 12-29-69	24c. NAME OF CEMETERY OR CREMATORY: Columbia Cemetery	24d. LOCATION (City, town, or county) (State): Columbia S.C.
DATE REC'D BY LOCAL REG.: Dec. 26, 1969	REGISTRAR'S SIGNATURE: Myrtle Palmer by car	25. EMBALMER: Erle B. Byram [signature]	LICENSE NO.: E-533

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5511
Local Reg. No. 958
Reg. Dist. No. 370

RECEIVED
Bureau of Vital Statistics
JAN 13 1970

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale, Idaho
d. STREET ADDRESS (If rural, give location): Box 1025

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	BLANCHE	ELIZABETH	CARSON		12	26	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married	May 30, 1898	71	6	26		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Self	Butte, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Philip Kloepfer	Germany	Louise A Lehman	Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	Unknown	X [signature] Carson	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) as understood by history

DUE TO (c) from husband

INTERVAL BETWEEN ONSET AND DEATH: 1 day

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	(Seen Stent had died before ever being

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert M Crane	MD	Boise Idaho	Jan. 7, 1970

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	12/30/69	Marsing-Homedale	Near Marsing, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 12, 1970	Myrtle Palmer	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 24 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Max Beal
315 W. Jefferson

Certificate of Death

STATE OF IDAHO

State File No. 5512
Local Reg. No. 948
Reg. Dist. No.

RECEIVED
JAN 7 1970
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital 52

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2900 Wymosa

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Marion	M.	Lee	12	26	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	6/7/1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer-Carpenter #1	Construction	Banner Co. (Harrisberg) Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William A. Lee	New York	Mae Dorman	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-01-3859A	X Mrs Jessie Lee 2	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Acute Congestive Heart — 24 hrs.
DUE TO (c) Failure.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April 1, 1969, to Dec 26, 1969, that I last saw the deceased alive on Dec 26, 1967, and that death occurred at 3:45 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Mark L. Bell, 039 M.D.	Boise, Idaho	1/5/70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/31/69	Terrace Lawn Gardens	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7 1970	Myrtle Palmer	Clyde J. Vassar	E-535

FIRM NAME: Cloverdale Funeral Home 375-2212

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 5 1970
Bureau of Vital Statistics

State File No. 5513
Local Reg. No. 939
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise	c. LENGTH OF STAY (In this place): 7 Days
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 612 Diamond Street

3. NAME OF DECEASED (Type or Print)	a. (First) PHOEBE	b. (Middle) L.	c. (Last) NEAL	4. DATE OF DEATH (Month) (Day) (Year) Dec. 26, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Nov. 13, 1918	9. AGE (In years last birthday): 51 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Spokane, Washington	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Joe Bolderson	BIRTHPLACE: ---	14. MOTHER'S MAIDEN NAME: Lillie (Unknown)	BIRTHPLACE: ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 551-14-7860	17. INFORMANT'S OWN SIGNATURE: [signature]	ADDRESS: 612 Diamond Nampa, Idaho	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

174X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Breast Cancer — INTERVAL BETWEEN ONSET AND DEATH: 3½ yrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 20, 1969 *to* Dec. 26, 1969, *that I last saw the deceased alive on* Dec. 26, 1969, *and that death occurred at* 2:30 PM *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 071 (Degree or title)	23b. ADDRESS: 848 La Cassia, Boise	23c. DATE SIGNED: 12-30-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12-29-69	24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: Jan. 2, 1970	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: [signature]	LICENSE NO.: E-497

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 13 1970 Bureau of Vital Statistics

State File No. 5514
Local Reg. No. 959
Reg. Dist. No. 270

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 20 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 337 E. Pine

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edward	Clinton	Tyler	Dec. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct. 31, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Steel	Rockland, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marvin Tyler	Utah	Emma Hunter	Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		X D Irwin Tyler	Council, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

492X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 15 yr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis N.D

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb 24, 1959, *to* Dec, 1969, *that I last saw the deceased alive on* Dec. 26, 1969, *and that death occurred at* 1:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
510		29 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-29-69	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 12, 1970	Myrtle Palmer	Jack H. Green	E-528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
JAN 2 1970
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5515
Local Reg. No. 932
Reg. Dist. No. 370
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2912 Gekeler Lane

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elizabeth	Leora	Graham	Dec. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced	March 17, 1928	41		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John P. Tate	Boise, Idaho	Marjorie Davis	Clarkston, Mich.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Wayne Tate	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

340X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bronchopneumonia	3 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Multiple Sclerosis	10 yr.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-30, 1968, *to* 12-27, 1969, *that I last saw the deceased alive on* 12-24, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Grayce R Baker DO, MD	Boise, Idaho	12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-31-1969	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 2, 1970	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 17 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
JAN 21 1970
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5516
Local Reg. No. 963
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 10 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2310 Grace Street

3. NAME OF DECEASED (Type or Print)
a. (First): FRANK
b. (Middle): H.
c. (Last): LINN

4. DATE OF DEATH (Month) (Day) (Year): Dec. 27, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: April 18, 1892
9. AGE (In years last birthday): 77
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian-Boise 08
10b. KIND OF BUSINESS OR INDUSTRY: School System
11. BIRTHPLACE (State or foreign country): Eden Valley, Minn.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Linn
BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Mary Alice Fergson
BIRTHPLACE: -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 533-16-3972
17. INFORMANT'S OWN SIGNATURE: Mrs. Norma Perry
ADDRESS: 2310 Grace St. Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2839

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Autoimmune Hemolytic Anemia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myeloproliferative Disorder — 6 mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Coronary Arteriosclerosis — 5 yrs
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 20, 1969, *to* Dec. 27, 1969, *that I last saw the deceased alive on* Dec. 27, 1969, *and that death occurred at* 10 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Maurice M. Rubbaldes, M.D. (Degree or title) 071
23b. ADDRESS: 848 La Cassia, Boise
23c. DATE SIGNED: 1/5/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-31-69
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Jan. 21, 1970
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 7 1970 Bureau of Vital Statistics

State File No. _____
Local Reg. No. 951
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Boise; c. LENGTH OF STAY (In this place): 10 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital	d. STREET ADDRESS (If rural, give location): 2310 Grace Street

3. NAME OF DECEASED (Type or Print)	a. (First) FRANK	b. (Middle) H.	c. (Last) LINN	4. DATE OF DEATH (Month) (Day) (Year) Dec. 27, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced	8. DATE OF BIRTH: April 18, 1892	9. AGE (In years last birthday): 77 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian Boise	10b. KIND OF BUSINESS OR INDUSTRY: School System	11. BIRTHPLACE (State or foreign country): Eden Valley, Minnesota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Linn	BIRTHPLACE	14. MOTHER'S MAIDEN NAME: Mary Alice Fergson	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 533-16-3972	17. INFORMANT'S OWN SIGNATURE: + Roberta A Linn	ADDRESS: Chelan, Wash.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Autoimmune Hemolytic Anemia	2 mos.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Myeloproliferative Disorder	6 mos.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Coronary Arteriosclerosis	5 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 20, 1969, *to* Dec. 29, 1969, *that I last saw the deceased alive on* Dec. 29, 1969, *and that death occurred at* 10 00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice M. Rubbed Sr., M.D.	23b. ADDRESS: 848 La Cassia, Boise	23c. DATE SIGNED: 1/5/70
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12-31-69	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho		
DATE REC'D BY LOCAL REG.: Jan. 7, 1970	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Dowell D. Demaray
LICENSE NO.: E-509		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5517
Local Reg. No. 929
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 1 Day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 3411 Rose Hill

3. NAME OF DECEASED (Type or Print)	a. (First) BETH	b. (Middle) SHAW	c. (Last) MARTIN	4. DATE OF DEATH (Month) (Day) (Year) Dec. 27, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Dec. 2, 1898	9. AGE (In years last birthday): 71 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 08: Clerk-Adams County	10b. KIND OF BUSINESS OR INDUSTRY: Treasurer Dept.	11. BIRTHPLACE (State or foreign country): Cassville, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Perry E. Maddox	BIRTHPLACE: Illinois	14. MOTHER'S MAIDEN NAME: Nancy Jane Woody	BIRTHPLACE: Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 530-12-4393	17. INFORMANT'S OWN SIGNATURE: X Dorothy L Hallett	ADDRESS: 2713 Esquire Dr. Boise, Idaho	

575X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Abscess of liver.	4-5 days.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cholecystitis -	4-5 days.
with ~~DUE TO (c)~~	Septicemic Shock	12 hrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pancreatitis,	24 hrs.

19a. DATE OF OPERATION

19b. ~~MAJOR~~ FINDINGS OF OPERATION: none

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 69, 19__, *to* Dec. 27, 19 69, *that I last saw the deceased alive on* Dec. 26, 19 69, *and that death occurred at* 5A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Robert Frazier, MD, 176 (Degree or title)	23b. ADDRESS: Boise, Idaho	23c. DATE SIGNED: Dec. 30, 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3	24b. DATE: 12-30-69	24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery	24d. LOCATION (City, town, or county) (State): Weiser, Idaho
DATE REC'D BY LOCAL REG.: Jan. 2, 1970	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Dowell D. Demaray	LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

~~JAN 2 1969~~
JAN 2 - 1970
OCT 15 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 7 1970 Bureau of Vital Statistics

State File No. 5518
Local Reg. No. 176
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (In this place) 21 DAYS
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL, BOISE, IDAHO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO
b. COUNTY JEFFERSON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RIGBY
d. STREET ADDRESS (If rural, give location) 127 CLARK STREET

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EARNEST	SHERMAN	THORNGREN	DECEMBER 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	WIDOWED	MAY 6, 1887	82	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SHEEPHERDER	sheep ranching	SOUTH DAKOTA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
FRANK J. THORNGREN	SWEDEN	SARAH RAPP	ILLINOIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI 3	518-12-7613	[signature]	VA HOSPITAL RECORDS, BOISE, IDAHO

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) / Arteriosclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH: 16 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Anemia, iron deficiency, cause undetermined. 9 mos.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I, VA, attended the deceased from DECEMBER 7, 19 69, to DECEMBER 28, 19 69, and that death occurred at 9:20 P m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Fred B. Hine M.D. 597 (Degree or title) FRED B. HINE, M.D., CHIEF, MEDICAL SERVICE	VA CENTER, BOISE, IDAHO	12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12-29-69		Rigby, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7 1970	Myrtle Palmer	Howell K Summers	E-509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service FORM OH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 14 1970
AUG 25 1975
NOV 2 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. Golby

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5519
Local Reg. No. 949
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada — JAN 7 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
c. LENGTH OF STAY (In this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1119 Emerald

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Firmin	C.	Stans	12	29	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	8/20/17	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender 23	Bar	Tuttle, No. Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Stans	Minnesota	Elizabeth Heller	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	W.W. 2 4	473-01-1192	Mrs Myrtle E. Brassfield	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7960

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Unknown - probable Coronary occlusion vs. Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Patient was S heartbeat or respiration at time of arrival at St Lukes Hospital

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. L. Golby, 735 M.D.		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1/2/70	Cloverdale Memorial Park	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7 1970	Myrtle Palmer	Clyde J. Vassar	E-535

FIRM NAME: Cloverdale Funeral Home 375-2212

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

4 - 1 Cert

JAN 7 1970
FEB 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5520
Local Reg. No. 920
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c/l
c. LENGTH OF STAY (In this place): 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 708 North 20th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada c/l
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 708 North 20th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOSEPH	W.	CROWE	Dec. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 25, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrical Engineer 09	Idaho Power Co.	Sherbrook, Canada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Crowe	Huntersfield, England	Emma Wilkinson	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	518-07-0913	Ruth W Martin	520 N 17 Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 53 *to* 12-30 69, *that I last saw the deceased alive on* 12-27 69, *and that death occurred at* 5:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree)	23b. ADDRESS	23c. DATE SIGNED
Frank Power 116 M.D.	116 West State	12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Entombment	1-2-70	Boise Mausoleum	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 2 1970	Myrtle Palmer	C. Dale McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 - 1970

MAR 4 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5521
Local Reg. No. 941
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
JAN 6 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1215 North 22nd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JESSIE	MAY	KOESTER	Dec. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Oct. 5, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Westpoint, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry A. Drebert	Westpoint, Nebraska	Anna Baas	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	No.	+ Helen R. Briggs	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4440

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Occlusion of the distal aorta (Leriche Syndrome), with loss of viability of the legs — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 16 December, 1969, *to* 30 December, 1969, *that I last saw the deceased alive on* 29 December, 1969, *and that death occurred at* 3:45a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Lyle Stones, M.D. 505 (Degree or title)	220 North 1st St., Boise, Ida.	1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	12-31-1969	Cloverdale Cemetery	Boise	Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 6, 1970	Myrtle Palmer	Elden T. Pearson	E-512

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 18 1970
JAN 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 10 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Swinehart 200 E Bannock

Certificate of Death
STATE OF IDAHO

State File No. 5522
Local Reg. No. 950
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 7 1970 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place): 6 hrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002	d. STREET ADDRESS (If rural, give location): 1905 Gourley

3. NAME OF DECEASED (Type or Print) a. (First): Thomas	b. (Middle): Anthony	c. (Last): Longden	4. DATE OF DEATH (Month) 12 (Day) 30 (Year) 69	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 1	8. DATE OF BIRTH: 12/29/69	9. AGE (In years last birthday) IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours 6 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Lowell T. Longden	BIRTHPLACE: West Virginia	14. MOTHER'S MAIDEN NAME: Sandra Baker	BIRTHPLACE: Emmett, Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: X Lowell T Longden	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Premature Birth — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ?
DUE TO (c): Due Date 4-3-70

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-29, 1969, *to* 12-30, 1969, *that I last saw the deceased alive on* 12-30, 1969, *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Ray T Swinehart 519 (Degree or title)	23b. ADDRESS: 200 E Bannock St	23c. DATE SIGNED: 1-5-70
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 1-2-70	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise, Idaho (State)		
DATE REC'D BY LOCAL REG.: Jan. 7 1970	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: G. W. Waters [signature] LICENSE NO. E-461

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home 375-2212

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

343-4281

State File No. 5523
Local Reg. No. 945
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Ada 011 JAN 7 1970	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau of Vital Statistics c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 710 N. 21st St. 000	d. STREET ADDRESS (If rural, give location) 710 N. 21st St.

3. NAME OF DECEASED (Type or Print) a. (First) Annie	b. (Middle) M.	c. (Last) Olson	4. DATE OF DEATH (Month) (Day) (Year) Dec. 30, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 22, 1882	9. AGE (In years last birthday) 87 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Chicago, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zacharias Dandanell	BIRTHPLACE Sweden	14. MOTHER'S MAIDEN NAME Mathilda Vessman	BIRTHPLACE Sweden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Carl R. Olson	ADDRESS 710 N. 21st	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4122

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac failure [illegible] to Hypertension

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arteriosclerotic cv disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: undetermined

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1957, *to* Dec, 1969, *that I last saw the deceased alive on* Nov 30, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE James A. Hawley MD (Degree or Title) 216	23b. ADDRESS 850 S Latah	23c. DATE SIGNED 2 Jan 70	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/2/70	24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Ada County, Idaho
DATE REC'D BY LOCAL REG. Jan. 5, 1970	REGISTRAR'S SIGNATURE Myrtle Palmer	25. EMBALMER J. Udell Magee	LICENSE NO. E-390

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics
JAN 6 1970

State File No. 5524
Local Reg. No. 942
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 12 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION: 520 Shoshone

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 520 Shoshone

3. NAME OF DECEASED (Type or Print): a. (First) HUGH b. (Middle) BARNUM c. (Last) EDDY

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 31, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 25, 1891

9. AGE (In years last birthday): 78
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. - Swan Falls
10b. KIND OF BUSINESS OR INDUSTRY: Idaho Power

11. BIRTHPLACE (State or foreign country): Vermont, Vergeness

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dwight E. Eddy
BIRTHPLACE: Vermont

14. MOTHER'S MAIDEN NAME: Mary Barnum
BIRTHPLACE: Vermont

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-54-5028

17. INFORMANT'S OWN SIGNATURE: x Flora C. Eddy
ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1530 Cancer of Right Colon — INTERVAL BETWEEN ONSET AND DEATH: 7/22/69

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Liver Metastesis — 7/22/69
DUE TO (c) Perforated bowel & General Peritonitis — 8/17/69

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 7/22/69
19b. MAJOR FINDINGS OF OPERATION: Cancer of Rt Colon & Gland & Liver Metast
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/28/69 to 12/31/69, that I last saw the deceased alive on _____ 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE: E. Jones M.D. (Degree or title: M.D.)
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-3-1970
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county): Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG.: Jan 6 1970
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Ward
LICENSE NO.: E 478

FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 6 - 1970

AUG 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5525
Local Reg. No. 960
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
JAN 20 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Boise
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise,
d. STREET ADDRESS (If rural, give location): 2725 N. 28th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Shawn
b. (Middle): Duane
c. (Last): Vold

4. DATE OF DEATH (Month) (Day) (Year): 12 31 69

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 12/28/69
9. AGE (In years last birthday): IF UNDER 1 YR. Months Days 3; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Duane Vold
BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Patricia Holtzclaw
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: X Dewayne A Vold
ADDRESS: 2725 N 28

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7469

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congenital heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/28/69 *19*____, *to* 12/31/69 *, 19*____, *that I last saw the deceased alive on* 12/31/69 *, 19*____, *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: George C Keeich 558 (Degree or title) MD
23b. ADDRESS: 218 N 1st Boise, Ida.
23c. DATE SIGNED: 1/6/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/2/70
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Memorial
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: Jan. 15 1970
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Clyde J. Vassar
LICENSE NO.: E-535

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5526
Local Reg. No. 952
Reg. Dist. No. 370
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Ada on JAN 7 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 8 days

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Ada on
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002
d. STREET ADDRESS (If rural, give location): 1316 North 5th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LaVina	Mae	Wallingford	12	31	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	11/15/1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 08	Statehouse	South Dakota	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred Laubert	South Dakota	Bette Rust	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	508-22-0989	X Louis Wallingford	1316 N. 5th Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Carcinoma of Rectum	2 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

1341

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Inoperable Rectal Cancer	Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 9, 19 69, to December 31, 19 69, *that I last saw the deceased alive on* _____, 19____ *and that death occurred at* 6:45 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	620 Hays St., Boise, Idaho	1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1-5-70	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7 1970	Myrtle Palmer	Lowell W. Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5527
Local Reg. No. 1
Reg. Dist. No. 300

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Adams 020 — JAN 5 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Indian Valley
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rural 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 1036 W. 7th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WALLACE	DEAN	FIELD	Nov.	9	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	married	June 5, 1931	38	5	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: O.K. Tire Store
11. BIRTHPLACE (State or foreign country): Wisner, Nebraska
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Julius Field — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Elma Field — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Mrs. Wallace Field — ADDRESS: Weiser

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound, Abdomen & chest — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe lacerations to Spleen, Stomach, Left lobe of liver.
DUE TO (c) Posterior heart, Left lower lobe.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): King Hill Drainage 31
21c. (CITY, TOWN, OR TOWNSHIP) 10 miles east & south of Indian Valley, Idaho (COUNTY) 13020 Adams (STATE) Idaho

21d. TIME OF INJURY (Month) 11 (Day) 9 (Year) 1969 (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Accidental Rifle discharge

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 12:30PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Harold Whitaker (Degree or title): Coroner
23b. ADDRESS: P.O. Box 215-Council, Idaho
23c. DATE SIGNED: 12/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: 1-2-70
REGISTRAR'S SIGNATURE:
25. EMBALMER: T. Dee Stimson
LICENSE NO.: E-388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 30 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 18 1969

State File No. 5528
Local Reg. No. 384
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bannock 030	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - McCammon
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 020	d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM	b. (Middle) JAMES	c. (Last) McCLURG	4. DATE OF DEATH (Month) (Day) (Year) Dec. 2, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Apr. 20, 1892	9. AGE (In years last birthday): 77 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Range Rider 04	10b. KIND OF BUSINESS OR INDUSTRY: Ranching	11. BIRTHPLACE (State or foreign country): Washington	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Bruce J. McClurg	BIRTHPLACE: Ohio	14. MOTHER'S MAIDEN NAME: Emma Jane Stephenson	BIRTHPLACE: Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I 3	16. SOCIAL SECURITY NO.: 547-07-5647A	17. INFORMANT'S OWN SIGNATURE: Mary F. McClurg	ADDRESS: McCammon, Idaho	

4369

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral Vascular accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Uremia ~~Poisoning~~ Poisoning
DUE TO (c): Arteriosclerose

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Strangulated Hernia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: Dec 1	19b. MAJOR FINDINGS OF OPERATION: Strangulated Hernia	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1950 Dec 2, 1969, *that I last saw the deceased alive on* Dec 1, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 070 (Degree or title)	23b. ADDRESS: Downey Id.	23c. DATE SIGNED: 12 5 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Dec. 6-1969	24c. NAME OF CEMETERY OR CREMATORY: McCammon Cem.	24d. LOCATION (City, town, or county) (State): McCammon, Idaho
DATE REC'D BY LOCAL REG.: 12-8-69	REGISTRAR'S SIGNATURE: Ila Mae Cunningham	25. EMBALMER: [signature]	LICENSE NO.: E-292

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 19 1969
JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5529
Local Reg. No. 377
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
DEC 12 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 599 Zener

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DARWIN	LEWIS	TILLEY	Dec. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never married	Dec. 6, 1958	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student -- Elementary School 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Corwyn Tilley
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Melva Gene Hicks
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: XXXX
17. INFORMANT'S OWN SIGNATURE: Corwyn L. Tilley
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2040

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Overwhelming systemic infection — INTERVAL BETWEEN ONSET AND DEATH: one day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute lymphoblastic leukemia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐:
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 19, 1966, to December 2, 1969, that I last saw the deceased alive on December 2, 1969, and that death occurred at 3:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Sydney A. Hornaday 133 (Degree or title)	Pocatello, Idaho	12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 4, 1969	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 1 1 1969	Gloria Dopita	Theron Miller	E-527

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5530
Local Reg. No. 386
Reg. Dist. No. 511

BIRTH NO.

RECEIVED

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 030 DEC 22 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Inkom
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 00

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Inkom
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOSEPH	E. (TED)	KING	Dec. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Oct. 11, 1928	41		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Logger 17	Logging	Brigham City, Utah	U.S.A.

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
Frank Claud King	Lillie Velete Whitaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No XXXX	518 3 0-6206	Jo Bax King Inkom, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of the pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3/20/69	Carcinoma of the pancreas with metastases.	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3/18/69 *, 19____, to* 12/3/69 *, 19____, that I last saw the deceased alive on* ____ *, 19____, and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. H. Horton 185 MD		12/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec.8,1969	Inkom Cemetery	Inkom, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 18 1969	Gloria Dopita		

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 22 1969
NOV 22 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5531
Local Reg. No. 383
Reg. Dist. No. 510

BIRTH NO.

RECEIVED Bureau of Vital Statistics DEC 18 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 610 West Bridger Street

3. NAME OF DECEASED (Type or Print): a. (First) WINSTON b. (Middle) EARL c. (Last) BEST

4. DATE OF DEATH (Month) (Day) (Year): December 4 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 24, 1899

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 70

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 22

10b. KIND OF BUSINESS OR INDUSTRY: Retail Grocery

11. BIRTHPLACE (State or foreign country): Salt Lake City Utah

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME | BIRTHPLACE: Walter C. Best | Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME | BIRTHPLACE: Ellen Croft | Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service): No | *****

16. SOCIAL SECURITY NO.: 528-03-9398

17. INFORMANT'S OWN SIGNATURE | ADDRESS: Wayne S. Best | Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: chronic

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Probable myocardial infarction — acute

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, *19* 64 *to* Dec. 4, *19* 69 *that I last saw the deceased alive on* Dec. 4, *19* 69 *and that death occurred at* 3:47 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L S Call, MD

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: Dec. 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 8, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: DEC 16 1969

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Jack Henderson

LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 5 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 8 1986

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5532
Local Reg. No. 350
Reg. Dist. No. 511

RECEIVED DEC 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Mem. Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grace- Star Route
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Harold Leroy Bassett

4. DATE OF DEATH (Month) (Day) (Year): Dec. 5, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Oct. 9, 1883

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Cattle

11. BIRTHPLACE (State or foreign country): Beaver Canyon, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles H. Bassett
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mary Lee
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-10-2981

17. INFORMANT'S OWN SIGNATURE: Earl Bassett
ADDRESS: Grace, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolus — INTERVAL BETWEEN ONSET AND DEATH: few days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atrial fibrillation — few days
DUE TO (c) Myocardial infarction — 2 or 3 wks

II. OTHER SIGNIFICANT CONDITIONS: Chronic lymphatic leukemia — several years
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1968, *to* Dec. 5, 1969, *that I last saw the deceased alive on* Dec. 5, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J E COMSTOCK, MD
23b. ADDRESS: Box 852-Pocatello, Idaho
23c. DATE SIGNED: 12-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/8/69
24c. NAME OF CEMETERY OR CREMATORY: Lago Cemetery
24d. LOCATION (City, town, or county) (State): Lago, Caribou, Idaho

DATE REC'D. BY LOCAL REG.: DEC 11 1969
REGISTRAR'S SIGNATURE: Glorene Dopita
25. EMBALMER: Leonard Allen
LICENSE NO.: E370

FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5533
Local Reg. No. 378
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Rest Home 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) MATTHEW b. (Middle) c. (Last) CLAWSON

4. DATE OF DEATH (Month) (Day) (Year) Dec. 6, 1969

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Sept.11, 1905
9. AGE (In years last birthday) 64 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Randolph, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Peter Clawson BIRTHPLACE
14. MOTHER'S MAIDEN NAME Jemmia Fackrell BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) XXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Matthew Bird Clawson ADDRESS

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Posterior Coronary — INTERVAL BETWEEN ONSET AND DEATH 10 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) occlusion - Coronary artery disease — 17 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Healing 3rd degree burns — 5 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Short Caught fire

22. *I hereby certify that I attended the deceased from* July, 1969, *to* 7 Dec 1969, *that I last saw the deceased alive on* 7 Dec, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Clark T Parker MD 406 (Degree or title)
23b. ADDRESS 343 W. Lewis Pocatello Ida
23c. DATE SIGNED 9 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec.9,1969
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. DEC 1 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER Theron Miller
LICENSE NO. E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 8 1969
JUN 1 0 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5534
Local Reg. No. 389
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019	d. STREET ADDRESS (If rural, give location) 344 Richland

3. NAME OF DECEASED (Type or Print) a. (First) IRENE	b (Middle) MARINDA	c. (Last) WARD	4. DATE OF DEATH (Month) (Day) (Year) Dec. 6, 1969	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan.20,1884	9. AGE (In years last birthday) 85 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Portage, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James L. John	BIRTHPLACE England	14. MOTHER'S MAIDEN NAME Mary James	BIRTHPLACE England	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) XXXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Willis R Ward	ADDRESS Pocatello, Idaho	

4121

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Inanition	sev'l mnths
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive arteriosclerotic heart disease with aortic stenosis	several years
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pernicious anemia	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 3, 1959, *to* Dec. 6, 1969, *that I last saw the deceased alive on* Dec. 6, 1969, *and that death occurred at* 5:20a *m., from the causes and on the date stated above.*

23a. SIGNATURE 101 John R. Comstock (Degree or title) J E Comstock MD	23b. ADDRESS Box 852-Pocatello-Idaho	23c. DATE SIGNED 12-16-69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec.9.1969	24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho		
DATE REC'D BY LOCAL REG. DEC 19 1969	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Leon Manning Jr.
LICENSE NO. E-537		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969
MAR 6 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5535
Local Reg. No. 398
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 294 Hillcrest Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 846 Poplar

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	CHARLES	WILLIAMS	Dec. 6, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		Aug. 9, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
oo		Pocatello, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Thomas Williams	Utah	Hannah Detton	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes World War II	561 14 1959	Guy F. Cash Jr	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Adenocarcinoma stomach — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Aug. 1969	Nonresectable cancer stomach	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7/15/69, 19__, *to* 12/6/69, 19__, *that I last saw the deceased alive on* 12/6/69, 19__, *and that death occurred at* 10:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	1448 East Center	12/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 9, 1969	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC	Gloria Dopita	[signature]	E-537

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 5536
Local Reg. No. 391
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031 DEC 23 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (In this place) Bureau of Vital Statistics	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arimo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAMINA	b. (Middle)	c. (Last) JENSEN	4. DATE OF DEATH (Month) (Day) (Year) Dec. 7, 1969	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 22, 1888	9. AGE (In years last birthday) 81 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Menden, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Kidman	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Williamina (Minnie) Yonk	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) XXXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE May Tillotson	ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Adenocarcinoma of Pancreas

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 12/2/69	19b. MAJOR FINDINGS OF OPERATION Nonresectible cancer of pancreas	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 5/14/69, 19__, *to* 12/7/69, 19__, *that I last saw the deceased alive on* 12/7/69, 19__, *and that death occurred at* 11:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE A. W. McRoberts (Degree or title)	23b. ADDRESS 1448 East Center	23c. DATE SIGNED 12/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 10, 1969	24c. NAME OF CEMETERY OR CREMATORY Arimo Cemetery	24d. LOCATION (City, town, or county) (State) Arimo, Bannock, Idaho
DATE REC'D BY LOCAL REG. DEC 19 1969	REGISTRAR'S SIGNATURE Gloria Dapila	25. EMBALMER Leo Manning Jr.	LICENSE NO. E-532

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 5537
Local Reg. No. 12
Reg. Dist. No. 51

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello, Idaho
LENGTH OF STAY (in this place): 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019
JAN 13 1970

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft, Idaho
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Ila b. (Middle) Mae c. (Last) Cummins Skinner

4. DATE OF DEATH: (Month) Dec. (Day) 9, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 29, 1921

9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Meadowville, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Grant Cummins — BIRTHPLACE: Gary, Indiana

14. MOTHER'S MAIDEN NAME: Jennie Bell — BIRTHPLACE: Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Kathleen Kunz — ADDRESS: Blackfoot, Ida 613 N. Shilling

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain stem injury — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Secondary To Basilar Skull Fracture
DUE TO (c) Trauma Auto accident.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractured Femur & Fractured Pelvis & Fractured ribs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): I 86 Highway

21c. (CITY, TOWN, OR TOWNSHIP) Pocatello (COUNTY) Bannock (STATE) Idaho.

21d. TIME OF INJURY (Month) Dec (Day) 9 (Year) 1969 (Hour) 3:22 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Automobile Accident

22. *I hereby certify that I attended the deceased from* Dec 9, 1969, *to* Dec 9, 1969, *that I last saw the deceased alive on* Dec 9, 1969, *and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. W. McRoberts M.D. — **23b. ADDRESS**: 1448 East Center — **23c. DATE SIGNED**: 12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal — **24b. DATE**: Dec. 9, 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Meadowville Cemetery — **24d. LOCATION** (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: JAN 6 1970 — **REGISTRAR'S SIGNATURE**: Gloria Dopita — **25. EMBALMER**: John P. Thomas — **LICENSE NO.**: E-292

FIRM NAME: Whitman Matthews Mortuary Soda SPRINGS, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5538
Local Reg. No. 389
Reg. Dist. No. 510

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 021
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 134 South 19th. Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 021
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 134 South 19th. Avenue

3. NAME OF DECEASED (Type or Print): a. (First) E. b. (Middle) LEON c. (Last) MYERS

4. DATE OF DEATH (Month) (Day) (Year): December 10 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 7, 1920

9. AGE (In years last birthday): 49
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radiologist 21

10b. KIND OF BUSINESS OR INDUSTRY: Medical

11. BIRTHPLACE (State or foreign country): Stark City Missouri

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Roy E. Myers
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Lorah May Everett
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Korean War 6

16. SOCIAL SECURITY NO.: 518-54-2010

17. INFORMANT'S OWN SIGNATURE: Ruth Ann Myers
ADDRESS: Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4119

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic coronary insufficiency — app. 3 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes mellitus — several years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov. , 19 55 *to* Dec. 10, 1969, *that I last saw the deceased alive on* Dec. 9, 1969, *and that death occurred at* 7:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J E Comstock, MD
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Dec. 12, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: Dec. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY: Aultorest Memorial Corp
24d. LOCATION (City, town, or county) (State): Ogden Utah

DATE REC'D BY LOCAL REG.: DEC 19 1969
REGISTRAR'S SIGNATURE: Gloria Coppie
25. EMBALMER:
LICENSE NO.: E - 349
FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 1 1 1975

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5539
Local Reg. No. 387
Reg. Dist. No. 510

BIRTH NO.

RECEIVED DEC 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this hospital or other institution) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Community Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 349 N. Hayes

3. NAME OF DECEASED (Type or Print) a. (First) CATHERINE b. (Middle) EILEEN c. (Last) MARTIN

4. DATE OF DEATH (Month) (Day) (Year) Dec. 12, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 5, 1905

9. AGE (In years last birthday) 64
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY Education

11. BIRTHPLACE (State or foreign country) Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Stack BIRTHPLACE Minn.

14. MOTHER'S MAIDEN NAME Mary O'Connell BIRTHPLACE Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-60-4861

17. INFORMANT'S OWN SIGNATURE James A. Martin ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 3 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1960, 19__, to 12-12-, 19 69, that I last saw the deceased alive on 12-12-, 19 69, and that death occurred at 915 m., from the causes and on the date stated above.

23a. SIGNATURE Donald C. Miller, M.D. (Degree or title)

23b. ADDRESS Pocatello, Idaho

23c. DATE SIGNED 12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 15-69

24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem

24d. LOCATION (City, town, or county) (State) Pocatello, Idaho

DATE REC'D BY LOCAL REG. DEC 18 1969

REGISTRAR'S SIGNATURE Gloria Dopita

25. EMBALMER John P. Downard

LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 24 1969
JAN 2 1970
JAN 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
JAN 9 1984
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5540
Local Reg. No. 3
Reg. Dist. No. 510

RECEIVED JAN 6 1970

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 037
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital C18

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 037
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1240 Palmer Lane

3. NAME OF DECEASED (Type or Print): a. (First) CONNIE; b. (Middle); c. (Last) CHRISTENSEN

4. DATE OF DEATH (Month) (Day) (Year): Dec. 13, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Aug. 11, 1953

9. AGE (In years last birthday): 16
IF UNDER 1 YR.: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: High School

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Garth C. Christensen
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Betty Flanders
BIRTHPLACE: Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXX

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Garth C Christensen 1240 Palmer
ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 486X Massive bilateral pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Juvenile dibetis melitus — 3yrs 5 mon.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 7, 1966, 19 *to* Dec. 13, 19 69, *that I last saw the deceased alive on* Dec. 13, 19 69, *and that death occurred at* 7:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard E. Ostler MD

23b. ADDRESS: 246 No. 18th Pocatello, Idaho

23c. DATE SIGNED: 12/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 16, 1969

24c. NAME OF CEMETERY OR CREMATORY: Arimo Cemetery

24d. LOCATION (City, town, or county) (State): Arimo, Bannock, Idaho

DATE REC'D BY LOCAL REG.: JAN 5 1970

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Leon Manning

LICENSE NO.: E-537

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 30 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5541
Local Reg. No. 393
Reg. Dist. No. 5

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031 — JAN 2 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 416 Wayne

3. NAME OF DECEASED (Type or Print) a. (First) ROSA b. (Middle) MAE c. (Last) COOKE (GIFFORD)

4. DATE OF DEATH (Month) (Day) (Year) December 17, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Feb. 26, 1901

9. AGE (In years last birthday): 68
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Crab Orchard, Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rufus Grayson — BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Martha E. Hoskins — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) XXXX

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Da Vaughn A. Gifford — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4123 Arteriosclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH: yrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive heart disease
DUE TO (c) Chronic heart failure

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Recent cerebral thrombosis — 2 wks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1960, 19__, to 12-17-, 19 69, that I last saw the deceased alive on __, 19__, and that death occurred at __ m., from the cause and on the date stated above.

23a. SIGNATURE (Degree or Title): Donald C. Miller M.D.

23b. ADDRESS: Pocatello Idaho

23c. DATE SIGNED: 12-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 20, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: DEC 30 1969

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Theron Sgilder

LICENSE NO.: E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5542
Local Reg. No. 19
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
JAN 16 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 354 Willard

3. NAME OF DECEASED (Type or Print): a. (First) LAURA; b. (Middle); c. (Last) SORENSEN

4. DATE OF DEATH (Month) (Day) (Year): December 17, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 6, 1931

9. AGE (In years last birthday): 38
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ezra Bagley
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Ruby Stratford
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXX

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Thos Sorenson
ADDRESS: 354 Willard

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2552

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ventricular arrythmias

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pheochromocytoma
DUE TO (c) complicated by pulmonary infarction

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: Dec 16, 1969

19b. MAJOR FINDINGS OF OPERATION: Fibroid Uterus

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-8, 1966, to 12-17, 1969, that I last saw the deceased alive on 12-17, 1969, and that death occurred at 7:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE: Calvin Buhler M.D. 069 (Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: JAN 18 1970

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Theron Miller

LICENSE NO.: E-534

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 1 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5543
Local Reg. No. 35
Reg. Dist. No. 5-10

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
JAN 22 1970
b. CITY OR TOWN Pocatello
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give township) (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Community Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Pocatello Heights - Apt. 10G

3. NAME OF DECEASED (Type or Print)
a. (First) WATSON
b. (Middle) RUSSELL
c. (Last) SAYRE

4. DATE OF DEATH (Month) (Day) (Year) December 18, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH December 22, 1890
9. AGE (In years last birthday) 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Chemist
10b. KIND OF BUSINESS OR INDUSTRY U. S. Steel Corp
11. BIRTHPLACE (State or foreign country) Evans West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Josephus Sayre
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Caroline Hogsett
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) *****
16. SOCIAL SECURITY NO. 169-07-3137
17. INFORMANT'S OWN SIGNATURE Lorna W Sayre
ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) sudden rupture of proximal anastamosis of dacron artery graft of abdominal aorta with massive hemorrhage into peritoneal cavity — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) due to previous surgery of aneurysm of abdominal aorta — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* Dec. 18, 19 69, *that I last saw the deceased alive on* Dec. 18, 19 69, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE John R. McMahon 347 (Degree or title) M.D.
23b. ADDRESS Pocatello, Idaho
23c. DATE SIGNED Jan. 20, 1970

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 1969
24c. NAME OF CEMETERY OR CREMATORY Otterbein Cemetery
24d. LOCATION (City, town, or county) Evans (State) West Virginia

DATE REC'D BY LOCAL REG. JAN 21 1970
REGISTRAR'S SIGNATURE Ilona Dopita
25. EMBALMER
LICENSE NO. E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 27 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 5 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 7 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 16 1974

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

OCT 30 1974

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5544
Local Reg. No. 3933
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Comm. Hospital C.G

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 242 Ravine Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WINIFRED	GRACE	CARSON	Dec.	20	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Mar. 5, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Bethel, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
A. Jacob Coulter	Minnesota	Mary M. Cochran	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-30-6821	Ralph F. Carson	Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

174X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of Breast with generalized Metastatis — INTERVAL BETWEEN ONSET AND DEATH: 1966

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	C a of Breast - 3-15-66.	Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1955, 19__, *to* 12-20-69, 19__, *that I last saw the deceased alive on* 12-20-69, 19__, *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David C. Miller 36 M.D.	Pocatello Idaho	12-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Dec. 23, 1969	Mount Moriah	Pocatello	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 29 1969	Gloria Dopita	George W. Knapp	409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 8 1970
JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5545
Local Reg. No. 40
Reg. Dist. No. 511

BIRTH NO.

RECEIVED JAN 23 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) 20 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location) Route 3

3. NAME OF DECEASED (Type or Print)
a. (First) MARY
b. (Middle) E.
c. (Last) COTTON KIRKPATRICK

4. DATE OF DEATH (Month) (Day) (Year) December 20, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH November 12, 1893
9. AGE (In years last birthday) 76
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Manessa, Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Cotton
BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Emma Barzee
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Louise Dechant
ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1979

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Metastatic carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mild diabetes mellitus — 10 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1957, *to* December 20, 1969, *that I last saw the deceased alive on* December 20, 1969 *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE L. H. Anderson (Degree or title) M.D. 009
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED Dec 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE December 24, 1969
24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery
24d. LOCATION (City, town, or county) Blackfoot (State) Idaho

DATE RECEIVED BY LOCAL REG. JAN 21 1970
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER E. Dean Hill
LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 5546
Local Reg. No. 4
Reg. Dist. No. 5-10

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 JAN 6 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 6 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Nursing Home 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 212½ Yellowstone Ave.

3. NAME OF DECEASED (Type or Print): a. (First) FRANCES; b. (Middle) THURZA; c. (Last) NELSON

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 20, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 15, 1902

9. AGE (In years last birthday): 67
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Darwin Epard
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Cora Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Carl B Nelson
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 514X Probable hypostatic pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Depression
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Cerebrovascular accident

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 12, 19 65 *to* December 20, 19 69, *that I last saw the deceased alive on* December 20, 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: L S Call MD
(Degree or title)

23b. ADDRESS: Box 852-Pocatello, Idaho

23c. DATE SIGNED: 12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: DEc.23-69

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: JAN 5 1970

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: John P. Downard

LICENSE NO.: E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH–63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5547
Local Reg. No. 9
Reg. Dist. No. 510

BIRTH NO.

RECEIVED Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 — JAN 5 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): c/8 Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 442 South Sixth Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DULCIE	NEWCOMB	WRIGHT	Dec. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Dec. 5, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Salt Lake City, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Simeon Saxton		Sarah K. Mellvish	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Ruth L. Wright	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

887 X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bilateral pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 23 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture of left hip — 25 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
XX /	Home 01	Pocatello 13c 31	Bannock	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Nov 25, 1969 m.		Fell at home

22. *I hereby certify that I attended the deceased from* November 25, 19 69, *to* December 20, 19 69, *that I last saw the deceased alive on* December 20, 19 69, *and that death occurred at* 8:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
009 Grandison MD	P. O. Box 4884 Pocatello, Idaho 83201	12-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec. 23, 1969	Pioneer Cemetery	Rigby, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JAN 2 1970	Glenn Draper	Theron Miller	E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 6 1970 AUG 12 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5548
Local Reg. No. 1
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031 — JAN 5 1970
b. CITY OR TOWN Pocatello
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1146 North Garfield Avenue

3. NAME OF DECEASED (Type or Print) — a. (First) JAMES — b. (Middle) J. — c. (Last) YOWELL

4. DATE OF DEATH (Month) (Day) (Year) December 20 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH December 16, 1907

9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partsman 21

10b. KIND OF BUSINESS OR INDUSTRY Automotive Parts Co.

11. BIRTHPLACE (State or foreign country) Marquette Kansas

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME — BIRTHPLACE: Chester Yowell — Marquette, Kansas

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Dell Palnquist — Lindsburg, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) *****

16. SOCIAL SECURITY NO. 519-07-1478

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Mrs James J. Yowell — Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1701 Carcinoma of Lt. Lung

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Jaw with Brain metastases

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO XXX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1957, 19___, *to* Dec. 20, 19 69, *that I last saw the deceased alive on* Dec. 20, 19 69, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 36 David E. Miller (Degree or title) M.D.

23b. ADDRESS Pocatello Idaho

23c. DATE SIGNED Dec. 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 23, 1969

24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery

24d. LOCATION (City, town, or county) Pocatello (State) Idaho

DATE REC'D BY LOCAL REG. JAN 2 1970

REGISTRAR'S SIGNATURE Gloria Dopita

25. EMBALMER Jack Henderson

LICENSE NO. E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5549
Local Reg. No. 394
Reg. Dist. No. 511

BIRTH NO.

JAN 2 1970
Bureau of Vital Statistics

1. PLACE OF DEATH D.O.A.
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Community Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) ELSIE b. (Middle) c. (Last) BROWN

4. DATE OF DEATH (Month) (Day) (Year) December 21, 1969

5. SEX Female
6. COLOR OR RACE Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH July 20, 1896
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekkepper 01
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Idaho Bob Smith Creek (Bannock Co.)
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Bob Smith BIRTHPLACE
14. MOTHER'S MAIDEN NAME Mary (no data) BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) *****
16. SOCIAL SECURITY NO. *****
17. INFORMANT'S OWN SIGNATURE Mrs Cecelia M. Ottogary ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal Chest Injuries — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Skull fracture
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Yellowstone Avenue 04
21c. (CITY, TOWN, OR TOWNSHIP) Pocatello 13031 (COUNTY) Bannock (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec. 21, 1969 11:40a
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Head-on Automobile Accident

22. *I hereby certify that I attended the deceased from ~~xxxxxxxxxxxx, 19xx, to xxxxxxxxxxxx, 19xx~~, that I last saw the deceased dead alive on* Dec. 21, 1969, *and that death occurred at* about 11:40a *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton John 583 4 (Degree or title) Bannock County Coroner
23b. ADDRESS Pocatello, Ida
23c. DATE SIGNED Dec. 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 24, 1969
24c. NAME OF CEMETERY OR CREMATORY Bannock Creek Cemetery
24d. LOCATION (City, town, or county) Bannock County (State) Idaho

DATE REC'D BY LOCAL REG. DEC 31 1969
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER Jack Henderson
LICENSE NO. E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as deffred by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5550
Local Reg. No. 9
Reg. Dist. No. 5-10

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03 JAN 9 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 375 Willard

3. NAME OF DECEASED (Type or Print): a. (First) VINCENT b. (Middle) B. c. (Last) LARSEN

4. DATE OF DEATH (Month) (Day) (Year): Dec. 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Apr. 20, 1897

9. AGE (In years last birthday): 72
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 56

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Paradise, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J.N. Larsen
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Ellen Bickmore
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Florence Larsen
ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Uremia - Anemia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma Prostate — 4 Yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9/14/69

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Prostate

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 2, 1966, to Dec 21, 1969, that I last saw the deceased alive on Dec 20, 1969, and that death occurred at 2 p.m., from the causes and on the date stated above.

23a. SIGNATURE: C.E. Larsen, M.D. (Degree or title)

23b. ADDRESS: 1505 E. Center

23c. DATE SIGNED: Jan 5/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 24, 1969

24c. NAME OF CEMETERY OR CREMATORY: Logan Cemetery

24d. LOCATION (City, town, or county) (State): Logan, Utah

DATE REC'D BY LOCAL REG.: JAN 6 1970

REGISTRAR'S SIGNATURE: Florence Loretta

25. EMBALMER

LICENSE NO.: E-537

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 9 1970

FEB 17 1970
NOV 17 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5551
Local Reg. No. 6
Reg. Dist. No. 510

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 03 JAN 6 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 018 Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1328 North Arthur

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HENRY	CHASE	CHATTERTON	Dec. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb.19,1883	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bricklayer	Construction	Logan, Utah	U.S.A.

13. FATHER'S NAME BIRTHPLACE	14. MOTHER'S MAIDEN NAME BIRTHPLACE
Heber C. Chatterton	Emma Howett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No	XXXX		George Henry Chatterton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 46 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 5 years
DUE TO (c) Generalized arteriosclerosis, severe, unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* October 20, 1969, *to* December 22, 1969, *that I last saw the deceased alive on* December 22, 1969, *and that death occurred at* 6:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	1448 E. Center, P. O. Box 4884, Pocatello, Ida	12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	December 26, 1969	Mountainview Cemetary	Pocatello, Bannock Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JAN 5 1970	Gloria Deputy		E-537

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 9 1970 -
SEP 30 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5552
Local Reg. No. 73
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
JAN 13 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give T.C.): Pocatello
Bureau of Vital Statistics
LENGTH OF
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 406 Riverside Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WIELDON	DEMETT	CROMPTON	December 22 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	October 14, 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crameman 10
10b. KIND OF BUSINESS OR INDUSTRY: Union Pacific R. R.
11. BIRTHPLACE (State or foreign country): American Fork, Utah
12. CITIZEN OF WHAT COUNTRY: U. S. A

13. FATHER'S NAME: Robert D. Crompton — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Nora Misener — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 712-03-4903
17. INFORMANT'S OWN SIGNATURE (Mrs W D) Eunice A Crompton — ADDRESS: Pocatello, Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic myocardial heart disease — several yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 18, 19 69, *to* Dec. 22, 19 69, *that I last saw the deceased alive on* Dec. 22, 1969, *and that death occurred at* 9:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
009 L. H. Anderson, M. D.	Pocatello, Idaho	Dec. 26, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 27, 1969	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JAN 9 1970	Flora Doyle		E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 15 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 19 2011

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 12 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5553
Local Reg. No. 5
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 031 Bannock JAN 6 1970	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello c. LENGTH OF STAY (If not in hospital or institution) Bureau of Vital Statistics	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location) 326 No. Buchanan

3. NAME OF DECEASED (Type or Print) a. (First) Mabel	b. (Middle) Harriet	c. (Last) Makinson	4. DATE OF DEATH (Month) (Day) (Year) Dec. 22, 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 8, 1898	9. AGE (In years last birthday) 71 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred A. McCreedy	BIRTHPLACE Mich.	14. MOTHER'S MAIDEN NAME Hattie S. Learned	BIRTHPLACE Wisconsin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-10-8350	17. INFORMANT'S OWN SIGNATURE Thomas Makinson	ADDRESS Pocatello, Idaho	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease — 1 month

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-21, 1969, *to* 12-22, 1969, *that I last saw the deceased alive on* 12-22, 1969, *and that death occurred at* 5:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE M Wourne 774 (Degree or title) MD	23b. ADDRESS Kasiska	23c. DATE SIGNED 12-31-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE Dec. 26-1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Fall, Idaho
DATE REC'D BY LOCAL REG. JAN 5 1970	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER John P. Gossner	LICENSE NO. E-292

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5554
Local Reg. No. 31
Reg. Dist. No. 511

BIRTH NO.

RECEIVED
JAN 22 1970
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bannock 030	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 020	d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First): ANDREW	b. (Middle): QUIGLEY	c. (Last): ANDERSON	4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Apr.11,1911	9. AGE (In years last birthday): 58 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager--Downey Billard Poolhall 26	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Oxford, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Andrew A. Anderson	BIRTHPLACE: Utah	14. MOTHER'S MAIDEN NAME: Kate Quigley	BIRTHPLACE: Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): XXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Jacqueline Anderson	ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5719

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hepatitis Cirrhosis liver — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ascites

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Cholecystitis - Cirrhosis liver

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* Dec 23, 19 69, *that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 070	(Degree or title): [signature]	23b. ADDRESS: Downey Idaho	23c. DATE SIGNED: Jan 15 70
24a. BURIAL, CREMATION, REMOVAL (Specify): 0	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG.: 1-19-70	REGISTRAR'S SIGNATURE: Ila Mae Cunningham	25. EMBALMER: [signature]	LICENSE NO. E-537

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN6 1970 Bureau of Vital

State File No. 5555
Local Reg. No. 7
Reg. Dist. No. 5/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock a3/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital c/9

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock a3/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 157 Wayne

3. NAME OF DECEASED (Type or Print): a. (First) HERMAN b. (Middle) , c. (Last) PEARSON
4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1969
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 9, 1887
9. AGE (In years last birthday): 82
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glass Artist a1
10b. KIND OF BUSINESS OR INDUSTRY: Glass Art
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John D. Pearson
BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Anna Helena Johnson
BIRTHPLACE: Sweden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-09-8533A
17. INFORMANT'S OWN SIGNATURE: Mayme Pearson
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic heart disease
INTERVAL BETWEEN ONSET AND DEATH: Chronic

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute myocardial infarction

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 10, 19 66 *to* December 23, 19 69, *that I last saw the deceased alive on* December 23, 19 69, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L S Call, MD
23b. ADDRESS: Box 852 - Pocatello, Idaho
23c. DATE SIGNED: 12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: JAN
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: John P. Grossman
LICENSE NO.: E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 8 1970

JUN 25 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 29 1973
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5556
Local Reg. No. 20
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
JAN 16 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1002 Samuel

3. NAME OF DECEASED (Type or Print): a. (First) RICHARD; b. (Middle); c. (Last) HALL

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 25, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 7, 1917

9. AGE (In years last birthday): 52
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yard Engineer 10

10b. KIND OF BUSINESS OR INDUSTRY: U.P. Railroad

11. BIRTHPLACE (State or foreign country): Fitchburg, Kentucky

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME / BIRTHPLACE: John Hall

14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Greenia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 402 14 0332

17. INFORMANT'S OWN SIGNATURE / ADDRESS: Zola Hall Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized severe coronary arterio-sclerosis — 5 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 22, 19 69, *to* December 25, 19 69, *that I last saw the deceased alive on* December 25, 19 69, *and that death occurred at* 11:40 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: P.O. Box 4884 Pocatello, Idaho 83201

23c. DATE SIGNED: 1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 30, 1969

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: JAN 13 1970

REGISTRAR'S SIGNATURE: Gloria Rosata

25. EMBALMER: Theron Miller — LICENSE NO.: E-524

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5557
Local Reg. No. 10
Reg. Dist. No. 5-10

BIRTH NO.

RECEIVED
JAN 9 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 82 Ravine Drive

3. NAME OF DECEASED (Type or Print): a. (First) LOIS; b. (Middle); c. (Last) WINWARD

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 25, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb.14,1909

9. AGE (In years last birthday): 60
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Paris, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clarence Shepherd
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Anita Bowen
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: W W Winward
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3949

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Rheumatic valvular heart disease with mitral stenosis and insufficiency. — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic congestive heart failure — Years
DUE TO (c) secondary to #1 Renal failure with uremia. — Years
Right hemiplegia, old. — Day

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* May, 19 51, *to* December, 19 69, *that I last saw the deceased alive on* December 24, 19 69, *and that death occurred at* 11:15A, *from the causes and on the date stated above.*

23a. SIGNATURE: Arch Wigle, M.D. (Degree or title)

23b. ADDRESS: 1605 North Arthur, Pocatello, Idaho 83201

23c. DATE SIGNED: 1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec.29,1969

24c. NAME OF CEMETERY OR CREMATORY: Whitney Cemetery

24d. LOCATION (City, town, or county) (State): Whitney, Idaho

DATE REC'D BY LOCAL REG.: JAN 6 1970

REGISTRAR'S SIGNATURE: Gloria Dozier

25. EMBALMER:

LICENSE NO.: E 537

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 9 1970

SEP 21 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death; which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5558
Local Reg. No. 3 95
Reg. Dist. No. 5 10

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 — JAN 2 1970
b. CITY OR TOWN: Pocatello — Bureau of Vital Statistics — LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Whitman Hotel 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho — b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Whitman Hotel (122 So. Main St.)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CARL	EUGENE	KING	December 27 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	August 19, 1918	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Conductor 10	Union Pacific R. R.	Jellico Tennessee	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hefner King		Verda Moore	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War II 4	520-05-4706	Connie A. King	Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Overdose Drugs — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Tuberculosis - pulmonary
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
1	Hotel Room 15	Pocatello 13 031	Bannock	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
12-27-69 m.		Drug overdose

22. *I hereby certify that I attended the deceased from* [illegible], *that I last saw the deceased alive on* Dec. 27, 1969, *and that death occurred at* [illegible], *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton Johns 583	Bannock County Coroner	Pocatello, Idaho	Dec. 31, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Dec. 31, 1969	Mountainview Cemetery	Pocatello	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	28. EMBALMER	LICENSE NO.
DEC 31 1969	Gloria Dopita	Jack Henderson	E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 29 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5559
Local Reg. No. 21
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 030 JAN 16 1970	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Robin c. LENGTH OF STAY (In this place) Bureau of Vital Statistics	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Robin
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) CLAUDE	b. (Middle) ELIAS	c. (Last) CHRISTENSEN	4. DATE OF DEATH (Month) (Day) (Year) Dec. 28, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 13, 1931	9. AGE (In years last birthday) 38 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Marysville, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Evan Elias Christensen	BIRTHPLACE Idaho	14. MOTHER'S MAIDEN NAME Sarah Jane Larson	BIRTHPLACE Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) Korean Con. 6	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Jerry L. Christensen	ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

9220

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) GUN-SHOT Wound, Chest — INTERVAL BETWEEN ONSET AND DEATH Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 31	21c. (CITY, TOWN, OR TOWNSHIP) 13030 (COUNTY) Robin Bannock (STATE) Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12.28.69 1:00 A.m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Accidently Shot self in Chest Cleaning Gun	

22. *I hereby certify that I attended the deceased from* — *, 19___, to* — *, 19___, that I ~~last~~ saw the deceased ~~alive~~ dead on* 12.28.69 *, and that death occurred at* 1:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton H. John 5834 (Degree or title) Coroner	23b. ADDRESS Bannock Co. Ida.	23c. DATE SIGNED 1-13-70	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 31, 1969	24c. NAME OF CEMETERY OR CREMATORY Robin Cemetery	24d. LOCATION (City, town, or county) (State) Robin, Bannock, Idaho
DATE REC'D BY LOCAL REG. JAN 14 1970	REGISTRAR'S SIGNATURE Gloria Dopita	25. EMBALMER Leon Manning	LICENSE NO. E-537

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 16 1970

FEB 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 14 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 6 1970 Bureau of Vital Statistics

State File No. 5560
Local Reg. No. 8
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hillcrest Haven Rest Home 294	d. STREET ADDRESS (If rural, give location) 185 Park

3. NAME OF DECEASED (Type or Print) a. (First) Sarah	b. (Middle) Luella	c. (Last) Hendricksen	4. DATE OF DEATH (Month) (Day) (Year) Dec. 28, 1969		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 26, 1867	9. AGE (In years last birthday) 102	IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Mt. Pleasant, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lucius Nelson Scovil	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Sarah Libby McArthur	BIRTHPLACE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) XXXXX	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Rheva Jorgensen	ADDRESS Pocatello		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1969, *to* Dec 28, 1969, *that I last saw the deceased alive on* Dec 23, 1969, *and that death occurred at* 3 P *m., from the causes and on the date stated above.*

23a. SIGNATURE R Grandall 113 (Degree or title) MD	23b. ADDRESS Pocatello Ida	23c. DATE SIGNED Jan 2-90	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec.31,1969	24c. NAME OF CEMETERY OR CREMATORY Ucon Cemetery	24d. LOCATION (City, town, or county) (State) Ucon, Idaho
DATE REC'D BY LOCAL REG. JAN 5 1970	REGISTRAR'S SIGNATURE Gloria Dosita	25. EMBALMER Theron Miller	LICENSE NO. E-524

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

State File No. 5561
Local Reg. No. 15
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (In this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1001 Willow Lane

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Community Hospital 019

3. NAME OF DECEASED (Type or Print) a. (First) ELSIE b. (Middle) EDNA c. (Last) CONNELL
4. DATE OF DEATH (Month) (Day) (Year) Dec. 29, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 26, 1920
9. AGE (In years last birthday) 49
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beauty Operator 31
10b. KIND OF BUSINESS OR INDUSTRY Beauty Shop
11. BIRTHPLACE (State or foreign country) Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Kodesh BIRTHPLACE Czechoslovakia
14. MOTHER'S MAIDEN NAME Emily Novacek BIRTHPLACE Czechoslovakia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-14-8203
17. INFORMANT'S OWN SIGNATURE Clinton C. Connell ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1991 Chordoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Secondary Hypopituarism

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-9, 1967, to Dec 29, 1969, that I last saw the deceased alive on Dec. 28, 1969, and that death occurred at 5:25a m., from the causes and on the date stated above.

23a. SIGNATURE Calvin Buhler M.D. (Degree or title)
23b. ADDRESS Pocatello Idaho
23c. DATE SIGNED Jan 9-1970

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Dec. 29-69
24c. NAME OF CEMETERY OR CREMATORY Buhl Cem.
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. JAN 12 1970
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER John P. Thomas
LICENSE NO. E-292
FIRM NAME: Albertson-Dickard Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-208 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 1 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5562
Local Reg. No. 61
Reg. Dist. No. 510

BIRTH NO. 69-12039

RECEIVED JAN 9 1970 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello; c. LENGTH OF STAY (If in this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location): 654 West Halliday

3. NAME OF DECEASED (Type or Print)	a. (First) JULIE	b. (Middle) ANN	c. (Last) JOHNSON	4. DATE OF DEATH (Month) (Day) (Year) Dec. 29, 1969
5. SEX: Female	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married	8. DATE OF BIRTH: Dec. 28,1969	9. AGE (In years last birthday): IF UNDER 1 YR. Months Days 1; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02	10b. KIND OF BUSINESS OR INDUSTRY: XXXX	11. BIRTHPLACE (State or foreign country): Pocatello, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Murray L. Johnson	BIRTHPLACE: Idaho	14. MOTHER'S MAIDEN NAME: Lili Marlene Hiatt	BIRTHPLACE: Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): XXXXX	16. SOCIAL SECURITY NO.: XXXX	17. INFORMANT'S OWN SIGNATURE: Murray L. Johnson	ADDRESS	

777X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): ?

DUE TO (c): ?

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth, 29 Dec, 1969, *to* 29 Dec, 1969, *that I last saw the deceased alive on* 29 Dec, 1969, *and that death occurred at* 2:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Donald B. Roberts MD (Degree or title)	23b. ADDRESS: 527 South 12th Ave Pocatello	23c. DATE SIGNED: 5 Jan 70
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Dec.31,1969	24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem.Gardens,
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho		
DATE REC'D BY LOCAL REG.: JAN 7 1970	REGISTRAR'S SIGNATURE: Gloria Dopita	25. EMBALMER: [signature] LICENSE NO. E-532

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

JAN 5 1970

Bureau of Vital Statistics

69-12058

BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 5563
Local Reg. No.
Reg. Dist. No. 552

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lanark
c. LENGTH OF STAY (In this place) 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lanark
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Brent
b. (Middle) Amos
c. (Last) Wallentine

4. DATE OF DEATH (Month) (Day) (Year) Dec. 6. 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Dec. 6, 1969
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 1 hr.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Montpelier, Idaho
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Loraine Jr. Wallentine BIRTHPLACE Lanark
14. MOTHER'S MAIDEN NAME Ruth Hulme BIRTHPLACE Paris, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE L. Jr. Wallentine ADDRESS Lanark Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7588

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Primary Apnea — INTERVAL BETWEEN ONSET AND DEATH 20 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Probable - Biliary Atresia — Congeital

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 6, 19__, *to* _____, 19__, *that I last saw the deceased alive on* 3:27 P.M., 19__, *and that death occurred at* 3:47 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 675 (Degree or title) MD
23b. ADDRESS Montpelier - Idaho
23c. DATE SIGNED 12-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 9. 1969
24c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery
24d. LOCATION (City, town, or county) (State) Liberty Idaho

DATE REC'D BY LOCAL REG. 12/13/69
REGISTRAR'S SIGNATURE Ruby Gortcinsky
25. EMBALMER Nile Matthews
LICENSE NO. E 359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5564

Local Reg. No.

Reg. Dist. No. 552

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
c. LENGTH OF STAY IN this place
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dingle Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) Ray c. (Last) Bird

4. DATE OF DEATH (Month) (Day) (Year) Dec. 17. 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Jan. 11. 1891

9. AGE (In years last birthday) 78

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Dingle Idaho

12. CITIZEN OF WHAT COUNTRY? U. S. a

13. FATHER'S NAME Wm Henry Bird BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Maryann Sparks BIRTHPLACE Ft. Herriman Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-07-4393

17. INFORMANT'S OWN SIGNATURE Orrilla Bird ADDRESS Dingle Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

274X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Gout — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive Heart Failure — 3 weeks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 5, 19 69 to Dec 17, 19 69, that I last saw the deceased alive on Dec 17, 19 69, and that death occurred at 11:50 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Montpelier Id.

23c. DATE SIGNED 12/23/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 20. 1969

24c. NAME OF CEMETERY OR CREMATORY Dingle Cemetery

24d. LOCATION (City, town, or county) Dingle (State) Idaho

DATE REC'D BY LOCAL REG. 12/23/69

REGISTRAR'S SIGNATURE Ruby Gorcinsky

25. EMBALMER Vile Matthews

LICENSE NO. E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Certificate of Death

STATE OF IDAHO

State File No. 5565
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO. JAN 5 1970

1. PLACE OF DEATH
a. COUNTY Bureau of Vit Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
c. LENGTH OF STAY (in this place) 2½ Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hosp 024

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 040 Bear Lake
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Montpelier
d. STREET ADDRESS (If rural, give location) 244 So 7th St.

3. NAME OF DECEASED (Type or Print)
a. (First) Dungan
b. (Middle) Lourie
c. (Last) King

4. DATE OF DEATH (Month) (Day) (Year) Dec 29 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 14 1909

9. AGE (In years last birthday) 60
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager

10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.

11. BIRTHPLACE (State or foreign country) Montpelier Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Dr. S. H. King
BIRTHPLACE Nicholasville Tenn.

14. MOTHER'S MAIDEN NAME Annie Lourie
BIRTHPLACE Topeka, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 556-03-1752

17. INFORMANT'S OWN SIGNATURE Mary Lynn King
ADDRESS Montpelier

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cardiac Arrest
INTERVAL BETWEEN ONSET AND DEATH 5 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION July 1969
19b. MAJOR FINDINGS OF OPERATION Cervical Nodule Cancer

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 19 69, *to* Dec 29, 19 69, *that I last saw the deceased alive on* 12-29, 19 69, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS Montpelier Idaho

23c. DATE SIGNED 12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec 31 1969

24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery

24d. LOCATION (City, town, or county) (State) Montpelier Idaho

DATE REC'D BY LOCAL REG. 12/30/69

REGISTRAR'S SIGNATURE Ruby Gotcinsky

25. EMBALMER Dale Matthews

LICENSE NO. E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 20 1970

MAY 13 1971

SEP 7 1973

DEC 24 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5566
Local Reg. No. 53
Reg. Dist. No. 130

BIRTH NO.

RECEIVED DEC 11 1969 Vital Statistics Bureau of

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY IN (in this place): 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries 050
d. STREET ADDRESS (If rural, give location): Center St.

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) N. c. (Last) NELSON

4. DATE OF DEATH: (Month) Dec. (Day) 5 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 6, 1919

9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Nelson — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Anna Jacks — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 532-10-5789

17. INFORMANT'S OWN SIGNATURE: Irene E. Nelson — ADDRESS: St. Maries Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Carcinoma of Lung — 2 3yrs

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 8:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] MD

23b. ADDRESS: St. Maries Idaho

23c. DATE SIGNED: 6 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec 9 1969

24c. NAME OF CEMETERY OR CREMATORY: Rockford

24d. LOCATION (City, town, or county) (State): Rockford, Wash.

DATE REC'D BY LOCAL REG.: Dec. 8, 1969

REGISTRAR'S SIGNATURE: Donna Brown

25. EMBALMER: Gerald E. Browning — LICENSE NO.: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 30 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5567
Local Reg. No. 56
Reg. Dist. No. 130

BIRTH NO.

RECEIVED DEC 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY (050) Benewah
b. CITY OR TOWN St. Maries
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) (025) Benewah Comm. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Worley (28)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Francis	Cassidy	Dec.	8	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	May 10, 1906	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman
10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine
11. BIRTHPLACE (State or foreign country) California
12. CITIZEN OF WHAT COUNTRY? U-S-A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Cassidy	Unknown	Adeline Wilson	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) WWI
16. SOCIAL SECURITY NO. 532-20-5436
17. INFORMANT'S OWN SIGNATURE Julianna Wilson ADDRESS Worley, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5 Dec, 1969, *to* 8 Dec, 1969, *that I last saw the deceased alive on* 7 Dec, 1969, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. J. Thorton M.D.	St. Maries Idaho	11 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/10/69	Worley Catholic Cem.	Worley Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15, 1969	Donna Brown	Gerald Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 10 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 7 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Certificate of Death

STATE OF IDAHO

State File No. 5568
Local Reg. No. 57
Reg. Dist. No. 130

BIRTH NO. DEC 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) Few days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Comm Hosp 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah 050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) 219 9th Street

3. NAME OF DECEASED (Type or Print)
a. (First) Ray
b. (Middle) Louis
c. (Last) Boughton

4. DATE OF DEATH (Month) (Day) (Year) Dec. 13 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 14, 1883
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor 22
10b. KIND OF BUSINESS OR INDUSTRY St. Maries Variety Store
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Seth D. Boughton — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) Nom 4109
16. SOCIAL SECURITY NO. 532-32-2984
17. INFORMANT'S OWN SIGNATURE Mrs Burt Sanders — ADDRESS 801 Canarsie Orangevale, Cal

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Congestion Tract II & Intestinal Ileus — 14 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 30 Nov, 1969, *to* 13 Dec, 1969, *that I last saw the deceased alive on* 12 Dec, 1969, *and that death occurred at* 6 45 m., *from the causes and on the date stated above.*

23a. SIGNATURE W. G. Thurston 532 (Degree or title) MD.
23b. ADDRESS St. Maries Idaho
23c. DATE SIGNED 15 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 16, 1969
24c. NAME OF CEMETERY OR CREMATORY Woodlawn
24d. LOCATION (City, town, or county) (State) St. Maries, Idaho

DATE REC'D BY LOCAL REG. Dec. 17, 1969
REGISTRAR'S SIGNATURE Donna Brown
25. EMBALMER Gerald Browning — LICENSE NO. E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

DUTIES:

JUN 1 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 17 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 18 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 28 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5569
Local Reg. No. 58
Reg. Dist. No. 130

BIRTH NO.

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Santa
c. LENGTH OF STAY: 68 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Santa
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	HERMAN	RENFRO	Dec. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Sept. 24, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Woodswork	Logging	Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Renfro	Oregon	Lizzie Wilson	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-03-7836	Gerald S Renfro	3708 SE 14th A, Richland, Wash

4369

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA (Repeated) — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 1967, *to* 20 Dec, 1969, *that I last saw the deceased alive on* 26 Mar, 1969, *and that death occurred at* 1:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. O. Thurston 533	MD	St Maries Idaho	22 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 23, 1969	Woodlawn	St. Maries Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Donna Brown	Gerald E Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR - 4 1990

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED JAN 20 1970 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 5570
Local Reg. No. 1
Reg. Dist. No. 130

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY (050) Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
LENGTH OF STAY IN THIS PLACE 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) (025) Benewah Comm. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY (032) Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) 820 Elm

3. NAME OF DECEASED (Type or Print)
a. (First) Henry
b. (Middle) —
c. (Last) Straub

4. DATE OF DEATH (Month) (Day) (Year) Dec. 30 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan. 26 1888

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming (04)

10b. KIND OF BUSINESS OR INDUSTRY Diversified

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Straub
BIRTHPLACE Russia

14. MOTHER'S MAIDEN NAME Margaret Rude
BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-01-6382

17. INFORMANT'S OWN SIGNATURE Sarah Mason
ADDRESS St. Maries, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4709

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pyelonephritis, uremia — 3 wks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1969, *to* Dec 30, 1969, *that I last saw the deceased alive on* Dec 30, 1969, *and that death occurred at* 5:10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE B. A. Rapp (428) (Degree or title) M.D.

23b. ADDRESS St. Maries, Idaho

23c. DATE SIGNED 1-14-70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jan. 2, 1970

24c. NAME OF CEMETERY OR CREMATORY Woodlawn

24d. LOCATION (City, town, or county) St. Maries (State) Idaho

DATE REC'D BY LOCAL REG. Jan. 15, 1970

REGISTRAR'S SIGNATURE Donna Brown

25. EMBALMER Gerald Browning
LICENSE NO. E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 21 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5571
Local Reg. No. 181
Reg. Dist. No. 60

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bingham 060	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley, Rural c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley,
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000	d. STREET ADDRESS (If rural, give location) R# 2

3. NAME OF DECEASED (Type or Print)	a. (First) Kathleen	b. (Middle)	c. (Last) Cook	4. DATE OF DEATH (Month) Nov (Day) 5 (Year) 1969	
5. SEX Female	6. COLOR OR RACE Cac	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 28 1919	9. AGE (In years last birthday) 49	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Milo Bonneville	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Tom C Wilson	BIRTHPLACE London, England	14. MOTHER'S MAIDEN NAME Sarah Harmon	BIRTHPLACE Colonia, Mexico.,		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-12-6174	17. INFORMANT'S OWN SIGNATURE Alvin Cook	ADDRESS		

5699

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive hemorrhage in intestines — INTERVAL BETWEEN ONSET AND DEATH: About 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rupture of large blood vessel
DUE TO (c) Unknown reason

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) Rt 2 Shelley	(COUNTY) Bingham (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* I did not see person alive *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Carl Stetey 583 4 Coroner ~~(Degree or title)~~	23b. ADDRESS 321 E Walker Blackfoot	23c. DATE SIGNED 1-7-70	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-8-69	24c. NAME OF CEMETERY OR CREMATORY Hill Crest	24d. LOCATION (City, town, or county) Shelley, Bingham (State) Idaho
DATE REC'D BY LOCAL REG. Jan. 7, 1970	REGISTRAR'S SIGNATURE Dorothy J. Jones	25. EMBALMER Lloyd M Nalder	LICENSE NO. E 275

FIRM NAME: Nalder's Funeral Home.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 7 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5572
Local Reg. No. 168
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
LENGTH OF STAY (In this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Sterling
d. STREET ADDRESS (If rural, give location): Sterling

3. NAME OF DECEASED (Type or Print)
a. (First): Agnes
b. (Middle): Estella
c. (Last): Cummins

4. DATE OF DEATH: (Month) Dec. (Day) 1, (Year) 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	Widowed	Aug. 29, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	St. Joseph, Arizona	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John McLaws, Jr.	Salt Lake City, Utah	Sophia DeLaMare	Tooele, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	526-86-0650	Frank Cummins	Mesa, Arizona

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	PNEUMONIA	1 WEEK
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	CHRONIC MYELOGENOUS LEUKEMIA	2 MONTHS
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 18 Nov 1969, *to* 1 Dec 1969, *that I last saw the deceased alive on* 1 Dec 1969, *and that death occurred at* 9:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gary K. Haddock M.D.	Blackfoot, Idaho	12-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal & Bur.	12-6-69	Joseph City Cemetery	Joseph City, Arizona

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 5, 1969	Dorothy J. Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5573
Local Reg. No. 169
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot,
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blackfoot Memorial Rest Home 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley,
d. STREET ADDRESS (If rural, give location) 212 N. Byron

3. NAME OF DECEASED (Type or Print) a. (First) Lee b. (Middle) c. (Last) Whitmill
4. DATE OF DEATH (Month) Dec (Day) 2 (Year) 1969
5. SEX Male
6. COLOR OR RACE Cac
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 10 Dec 1891
9. AGE (In years last birthday) 77 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer ok
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Basalt, Idaho
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henry Roland Whitmill BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Luna Estella Searles BIRTHPLACE Payson, Utah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) WWI (If yes, give war or dates of service) 3
16. SOCIAL SECURITY NO. 518-09-8249
17. INFORMANT'S OWN SIGNATURE Don Whitmill ADDRESS Box 6 Shelley Ida

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular disease. — 10 years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 24, 1959 *to* Dec. 2, 1969 *that I last saw the deceased alive on* Dec. 2, 1969 *and that death occurred at* 6 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE Walter M Hoge 234. (Degree or title) MD
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED 4 Dec 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-5-1969
24c. NAME OF CEMETERY OR CREMATORY Basalt,
24d. LOCATION (City, town, or county) (State) Shelley Rt 1 Bingham Idaho

DATE REC'D BY LOCAL REG. 12-8-69
REGISTRAR'S SIGNATURE Dorothy J Jones
25. EMBALMER Lloyd M Yalden
LICENSE NO. E 275
FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAY 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5574
Local Reg. No. 170
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Stat

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bingham (061)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 28yr9mon.
d. FULL NAME OF HOSPITAL OR INSTITUTION: State Hospital South (033)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Minidoka (34c)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDITH	S.	STONE	December 5 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	17 Dec. 1900	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher (12)		Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas W. Welch	Missouri	Mattie Anne Cockrell	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 60 5478T	Mrs. [illegible]	Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pulmonary Embolism (4409)	3 hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized Arteriosclerosis	5 yrs.
DUE TO (c)	Post-Amputation Right Foot	1968
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5 December, 1969, *to* 5 December, 1969, *that I last saw the deceased alive on* 5 December, 19 69, *and that death occurred at* 3:35p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Owen F. Marlowe M.D.	State Hospital South-Blackfoot, Idaho	12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
burial (3)	Dec 10, 1969	Rupert cemetery	Rupert	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Burial DEC 16 1969	Dorothy J. Jones	L. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5575
Local Reg. No. 171
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham DEC 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 304 Bingham County nursing home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location) Route 1

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LITA	LOUISE	TAYSOM	December 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed	June 6, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Practical nurse 13	medicine	Oakley, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Aaron McBride	unknown	Coroline Cheney	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-10-8575		Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4310

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Intra cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertention Severe — unKnown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct , 19 69 *to* December 5 , 19 69 , *that I last saw the deceased alive on* December 5 , 19 69, *and that death occurred at* 5:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Blackfoot, Idaho	Dec 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3	Dec 10, 1969	Afton Cemetery	Afton Wyoming

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 16 1969	Dorothy J. Jones	C. Dean Hill	E-280

FIRM NAME Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5576
Local Reg. No. 172
Reg. Dist. No. 601

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 060 Bingham DEC 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley
c. LENGTH OF STAY (In this place) 6mo7days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 232 Schellenberg Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) Route #5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FERN	A.	TORGERSON	December 7 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	27 May 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Bernard Hunt	Iowa	Dorothy Boone	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	555 26 2563	Mary Layne	Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7 December, 1969, *to* 7 December, 1969, *that I last saw the deceased alive on* 7 December, 1969, *and that death occurred at* 8:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
594	State Hospital South-Blackfoot, Idaho	12-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
burial	Dec18,1969	State Hospital	Blackfoot	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 16 1969	Dorothy J. Jones	L. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

APR 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5577
Local Reg. No. 173
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sterling (Rural)
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) GIUSTINO b. (Middle) c. (Last) DeGIULIO

4. DATE OF DEATH (Month) (Day) (Year): December 8, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: May 18, 1883

9. AGE (In years last birthday): 86
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Dominico DeGiulio
BIRTHPLACE: Italy

14. MOTHER'S MAIDEN NAME: Teresa Unknown
BIRTHPLACE: Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-46-9638

17. INFORMANT'S OWN SIGNATURE:
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

600X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Septicemia Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 1½ week

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Benign Prostate Hypertrophy — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. diabetes mellitus, anemia, hypertension — years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* February, 19 65, *to* December 8, 19 69, *that I last saw the deceased alive on* December 8 19 69, *and that death occurred at* 1:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. E. Miller 36 (Degree or title): M.D.
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Dec 11, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 3
24b. DATE: Dec 11, 1969
24c. NAME OF CEMETERY OR CREMATORY: Tooele Cemetery
24d. LOCATION (City, town, or county) (State): Toole Utah

DATE REC'D BY LOCAL REG.: Dec. 19, 1969
REGISTRAR'S SIGNATURE: Dorothy L. Jones
25. EMBALMER: L. Dean Hill
LICENSE NO.: E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 8 1986

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 23 1969 Bureau of Vital Statistics

State File No. 5578
Local Reg. No. 174
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Bingham 061	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham County Nursing Home 029	d. STREET ADDRESS (If rural, give location) Route

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE	b. (Middle) FRANCIS	c. (Last) HILL	4. DATE OF DEATH (Month) (Day) (Year) December 10, 1969	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH September 22, 1894	9. AGE (In years last birthday) 75; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat cutter 21	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Sterling, Idaho	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Hill	BIRTHPLACE	14. MOTHER'S MAIDEN NAME Emma Wheeler	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS Blackfoot, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary occlusion	15 min
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	arterio sclerotic heart disease	5 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	chronic Bowel problem with Colostomy	1 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* _____, 19 60, *to* December 10, 19 69, *that I last saw the deceased alive on* December 10, 19 69, *and that death occurred at* 7:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) M.D.	23b. ADDRESS Blackfoot, Idaho	23c. DATE SIGNED Dec 11, 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial 3	24b. DATE December 13, 1969	24c. NAME OF CEMETERY OR CREMATORY Rest Lawn Cemetery	24d. LOCATION (City, town, or county) Pocatello (State) Idaho
DATE REC'D BY LOCAL REG. DEC 16 1969	REGISTRAR'S SIGNATURE Dorothy J. Jones	25. EMBALMER [signature]	LICENSE NO. E-466

FIRM NAME: Sandberg-Hill FuneralHome

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 5579
Local Reg. No. 175
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061 DEC 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
Bureau of Vital Statistics
LENGTH OF STAY (In this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 180 North Fisher St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	LEROY	ANDERSON	December 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 10, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		Central, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jens M. Anderson	Denmark	Caroline Hansen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-01-6631	Mrs. J. Leroy Anderson	Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 yr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart disease — 10 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1950, 19__, *to* December 11, 1969, *that I last saw the deceased alive on* December 11, 1969, *and that death occurred at* 6:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
404 M.D.	Blackfoot, Idaho	Dec 15, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	25. EMBALMER	LICENSE NO.
burial	Dec 15, 1969	Firth Cemetery	Firth Idaho		

DATE REC'D BY LOCAL REG. DEC 16 1969
REGISTRAR'S SIGNATURE Dorothy J. Jones
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5580
Local Reg. No. 177
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): Route # 3

3. NAME OF DECEASED (Type or Print)
a. (First): ELIZABETH
b. (Middle): HALE
c. (Last): JUDD

4. DATE OF DEATH (Month) (Day) (Year): December 14, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: October 4, 1882

9. AGE (In years last birthday): 87
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Gentile Valley, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jonathon H. Hale
BIRTHPLACE: Grantsville, Utah

14. MOTHER'S MAIDEN NAME: Eliza Clegg
BIRTHPLACE: Tooele, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE
ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic Brain Syndrome 3099 — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 12, 19 67 *to* December 14, 19 69, *that I last saw the deceased alive on* December 14, 19 69, *and that death occurred at* 8 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Dec 16, 69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec 18, 1969

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county): Blackfoot (State): Idaho

DATE REC'D BY LOCAL REG.: DEC 16 1969

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: L. Dean Hill

LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5581
Local Reg. No. 176
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY 007 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 21 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Pingree
d. STREET ADDRESS (If rural, give location) Pingree

3. NAME OF DECEASED (Type or Print)
a. (First) Martha
b. (Middle) Caroline
c. (Last) Walters

4. DATE OF DEATH (Month) Dec. (Day) 14, (Year) 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Sept. 4, 1885

9. AGE (In years last birthday) 84
IF UNDER 1 YR. Months 3 Days 10
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Logan, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Peter John Fjelsted
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Bertha Marie Jensen
BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-40-9234-B

17. INFORMANT'S OWN SIGNATURE A. E. Walters
ADDRESS Pingree, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 493X Status Asmaticus — INTERVAL BETWEEN ONSET AND DEATH 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 69 *to* Dec 14 1969 *that I last saw the deceased alive on* Dec 14 1969 *and that death occurred at* 11:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) M.D.

23b. ADDRESS 625 W. Pacific Blackfoot, Idaho

23c. DATE SIGNED 12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-17-69

24c. NAME OF CEMETERY OR CREMATORY Riverside-Thomas Cem.

24d. LOCATION (City, town, or county) (State) Thomas, Bingham, Idaho

DATE REC'D BY LOCAL REG. DEC 18

REGISTRAR'S SIGNATURE Dorothy L. Jones

25. EMBALMER Howard Packham

LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5582
Local Reg. No. 178
Reg. Dist. No. 600

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot,
c. LENGTH OF STAY in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley, Bingham
d. STREET ADDRESS (If rural, give location) 221 E. Elm

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Tamar	Y	Bleak	Dec	16	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Cac	Widowed	Dec 1 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Huntington, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lorenzo Sobieski Young	Ill	Sarah Amelia Black	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-4362
17. INFORMANT'S OWN SIGNATURE David L. Bleak ADDRESS

18. CAUSE OF DEATH 2509
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Generalized arteriosclerosis	5yr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Diabetes Mellitus	?
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Bilateral Blindness	?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1969, to Dec 16, 1969, that I last saw the deceased alive on Dec 16, 1969, and that death occurred at 8 P. m., from the causes and on the date stated above.

23a. SIGNATURE 404 (Degree or title) MD
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-20-69	Lincoln	Idaho Falls, Bonneville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 29 1969	Dorothy J. Jones	Lloyd M. Nalder Lloyd M. Nalder	E-275

FIRM NAME: Nalder's Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5583
Local Reg. No. 182
Reg. Dist. No. 600

69-6739

RECEIVED

BIRTH NO.

JAN 13 1970

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION 029 Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) FLOYVAN b. (Middle) c. (Last) CERINO

4. DATE OF DEATH (Month) (Day) (Year) December 21, 1969

5. SEX male

6. COLOR OR RACE Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH July 17, 1969

9. AGE (In years last birthday) IF UNDER 1 YR. Months 5 Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child 012

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Cerino
BIRTHPLACE Fort Hall, Idaho

14. MOTHER'S MAIDEN NAME Judy Box
BIRTHPLACE Fort Hall, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE
ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 485X Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 48hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to December 21, 19 69, that I last saw the deceased alive on December 21, 19 69, and that death occurred at 6:30a m., from the causes and on the date stated above.

23a. SIGNATURE J. M. Withers 529 (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED Dec 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE December 24, 1969

24c. NAME OF CEMETERY OR CREMATORY Ross Fork Creek

24d. LOCATION (City, town, or county) (State) Fort Hall Reservation, Ida

DATE REC'D BY LOCAL REG. Jan 7, 1969

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER C. Dean Hill

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5584
Local Reg. No. 183
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
LENGTH OF STAY (in this place) 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 14 North Stout St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FLORENCE	MARTINA	WERNETTE	December 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	married	January 30, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Oberlin, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ambrose Handwerk	Germany	Catherine Meisen	Fon-du-lac, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		E. M. Wernette	Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 486X Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumonia — 2 weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from December 15, 1969, to December 21, 1969, that I last saw the deceased alive on December 21, 1969, and that death occurred at 5:10p m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Walter E Hoge 234	M.D.	Blackfoot, Idaho	Dec 23, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	December 24, 69	Grove City Cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7, 1969	Dorothy J. Jones	L. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5585
Local Reg. No. 184
Reg. Dist. No. 600

BIRTH NO.

RECEIVED JAN 13 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 500 Sonny Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ARTHUR	MILLARD	LAMBSON	December 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	July 20, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Agriculture	Mackay, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alfred B. Lambson	Salt Lake City, Utah	Amelia DeWitt	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-07-4195		Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac Decompensation	3 yr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Emphysema	10 yr
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Polycythemia - Diabetes.	1 yr

492X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 60, *to* December 25, 19 69, *that I last saw the deceased alive on* December 25, 19 69, *and that death occurred at* 9:45a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 404	M.D.	Blackfoot, Idaho	Dec 26, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
burial 3	December 27, 69	Mt McCaleb Cemetery	Mackay	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7, 1969	Dorothy J Jones	[signature]	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5586
Local Reg. No. 179
Reg. Dist. No. 600

BIRTH NO. RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 2½ yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bingham Nursing Home 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 98 Poplar

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lillian	Josephine	Lamson	Dec.	26,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed	April 15, 1878	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	own home	Kewanee, Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nicholas Bregger	Germany	Josephine Tyler	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-22-8056	Mrs. Henry L. Burt	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cystitis, pyelonephritis, bacteriuria, Klebsiella — INTERVAL BETWEEN ONSET AND DEATH: 1 day / years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 17 Nov, 1969, to 26 Dec 69, 19____, *that I last saw the deceased alive on* 23 Dec 69, 19____, *and that death occurred at* 9:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. E. Mellen Jr	M.D.	9 Airport Rd. Blackfoot, Idaho	12-27-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-29-69	Grove City Cemetery	Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 29 1969	Dorothy J. Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED JAN 5 1970 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5587
Local Reg. No. 180
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bingham C61	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Utah 45 b. COUNTY: Salt Lake 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot — c. LENGTH OF STAY (In this place): 35 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Salt Lake City
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Nursing Home 304	d. STREET ADDRESS (If rural, give location): 3170 Kaibab Way

3. NAME OF DECEASED (Type or Print)	a. (First) Cordelia	b. (Middle)	c. (Last) Farnsworth	4. DATE OF DEATH (Month) Dec. (Day) 29, (Year) 1969
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: Sept. 20, 1879	9. AGE (In years last birthday): 90 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own home	11. BIRTHPLACE (State or foreign country): Richfield, Utah	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Olaf Anderson Andelin — BIRTHPLACE: Skane, Sweden		14. MOTHER'S MAIDEN NAME: Maria Lofdahl — BIRTHPLACE: Malma, Sweden		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 529-36-3127D	17. INFORMANT'S OWN SIGNATURE: Melba F. May	ADDRESS: Blackfoot, Idaho	

4124

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 8 Mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 10:45 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE: Gary K. Haddock 901 (Degree or title) M.D.	23b. ADDRESS: Blackfoot, Idaho 625 West Pacific	23c. DATE SIGNED: 12-30-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial 3	24b. DATE: 1-2-70	24c. NAME OF CEMETERY OR CREMATORY: Wasatch Lawn Mem. Park	24d. LOCATION (City, town, or county) (State): Salt Lake County, Utah
DATE REC'D BY LOCAL REG.: DEC 31 1969	REGISTRAR'S SIGNATURE: Dorothy J. Jones	25. EMBALMER: Howard Packham	LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5588
Local Reg. No. 40
Reg. Dist. No. 410

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 070
a. COUNTY Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bellevue
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence, Bellevue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bellevue
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) GLADYS
b. (Middle) GERALDINE
c. (Last) DRAGER

4. DATE OF DEATH (Month) (Day) (Year) Dec. 16, 1969

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH June 11, 1901
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Bramyer, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles F. Collins — BIRTHPLACE Wheeling, Mo.
14. MOTHER'S MAIDEN NAME Catherine Middleton — BIRTHPLACE Marrion, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-40-1435
17. INFORMANT'S OWN SIGNATURE [signature] Drager — ADDRESS 5610 LACOUR MONIQUE NEW ORLEANS, LA. 70114

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7963

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Presumed natural causes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Cl. Scott Earle MD 583 4 Coroner
23b. ADDRESS Sun Valley, Idaho
23c. DATE SIGNED 12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/20/1969
24c. NAME OF CEMETERY OR CREMATORY Bellevue Cemetery
24d. LOCATION (City, town, or county) (State) Bellevue, Idaho

DATE REC'D BY LOCAL REG. Dec. 29-1969
REGISTRAR'S SIGNATURE Robert H. Wright - per C.B.W.
25. EMBALMER Keith Bird — Keith Bird
LICENSE NO. E-373
FIRM NAME: Bird Funeral Home, Hailey, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5589
Local Reg. No. 41
Reg. Dist. No. 410

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Hailey
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East ForkWoodRiver 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): FRANK
b. (Middle): HENRY
c. (Last): KNIGHT

4. DATE OF DEATH (Month) (Day) (Year): Dec. 17, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 12, 1893
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Stock
11. BIRTHPLACE (State or foreign country): Hailey, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME / BIRTHPLACE: George H. Knight
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Flora Troger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 518-44-1153
17. INFORMANT'S OWN SIGNATURE: Irma M Knight — ADDRESS: Hailey, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3979

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart failure, acute (presumed) — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Rheumatic valvular disease — 50 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. Scott Eare MD 583 4 Coroner
23b. ADDRESS: Sun Valley, Idaho
23c. DATE SIGNED: 12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 12/20/69
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: Dec-29-1969
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird — Keith Bird
LICENSE NO.: E-373
FIRM NAME: Bird Funeral Home, Hailey, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021 per C.B.W.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 29 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 15 1978

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5590
Local Reg. No. 42
Reg. Dist. No. 410

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Blaine 070 — DEC 30 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write township) Hailey — LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blaine Co. Hospital 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Blaine 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LOTTIE	MAUDE	BARCUS	Dec. 21, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	white	widowed	January 25, 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Braymer, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Wells	UNK	Nancy Wilson	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	Lucien W. Barcus	Mt. Home, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1-2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Dis — several yrs.
DUE TO (c) [illegible]

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Generalized arteriosclerosis + uremia. several yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1964, *to* Dec 21, 1969, *that I last saw the deceased alive on* Dec 20, 1969, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Alden M Packard 407 (Degree or title)	Box 37 Hailey Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/23/69	Hailey Cemetery	Hailey, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 29-1969	Robert H. Wright	Keith Bird	E-373

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev 6-63 N. FIRM NAME: Bird Funeral Home Hailey, Idaho

DUTIES: JAN 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

State File No. 5591
Local Reg. No. 352
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 080 Boise	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 14 mi.-W-Idaho City c. LENGTH OF STAY (In this place) hrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rural- Hw'y. # 21, Idaho City 000	d. STREET ADDRESS (If rural, give location) 307 E. Bannock

3. NAME OF DECEASED (Type or Print)	a. (First) Linda	b. (Middle) Olson	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) 11/27/69	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/28/51	9. AGE (In years last birthday) 17	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress 06	10b. KIND OF BUSINESS OR INDUSTRY J's Big Boy	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Leon R. Olson	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE Irven R. Jones	ADDRESS		

8169

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1 Auto Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) App. Drowning 06	21c. (CITY, TOWN, OR TOWNSHIP) Rural 13080	(COUNTY) (STATE) Boise County
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-27-69 m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Richard H. Hanley 583 4	(Degree or title) Coronor Boise County	23b. ADDRESS Star Rt. Banks Ida.	23c. DATE SIGNED 1-7-70
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE 12/3/69	24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. 1/10/1970	REGISTRAR'S SIGNATURE Henrietta Penrod	25. EMBALMER Andrew P. Dembowski	LICENSE NO. E-527

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Mountain View Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5592
Local Reg. No. 352
Reg. Dist. No.

RECEIVED JAN 13 1970 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY (080) Boise
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) (000) 17 Miles N. Lowman, Hiway 21

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY (030) Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Rt. # 2, South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Donald	G.	Ridley	Dec. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Aug. 6, 1932	37		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Heavy Equipment Operator	Construction	New Mexico	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Virgil L. Ridley	Wapanucka, Okla.	Mary Young	Hall Co., Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean	465-32-8128	X Billy D Ridley	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION (8230)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable anoxia — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Crushed thoracic area
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple fractures, rt. arm. Multiple contusions, head & trunk

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (080) (COUNTY) (STATE)
Accident	State Hiway #21 (020)	17 Miles N. of Lowman, Boise Co., Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Dec. 12, 1969 8 a.m.	WHILE AT WORK [X] NOT WHILE AT WORK [ ]	while operating heavy road construction machine which overturned pinning him inside.

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard H. Hanley SR	Coroner	Star Route, Banks, Idaho	1-7-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12/13/1969	Mtn. View Cemetery	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1/10/70	Henrietta Penrod	Earl Waggoner	E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 13 1970
JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5593
Local Reg. No. #524
Reg. Dist. No.

BIRTH NO.

RECEIVED DEC 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glengary
c. LENGTH OF STAY (in this place): 8 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glengary
d. STREET ADDRESS (If rural, give location): Route 1, Sagle, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Fred		Shields	November 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Feb 28, 1901	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 054	Own farm	California	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Allen Shields	Indiana	Ella Gamblin	California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	------	518 16 3307	Mrs Fred Shields	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carbon monoxide Poisoning — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Self inflicted
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
2 Suicide	Residence 32	Glengary 13040 Bonner Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Nov 27, 1969 m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. Nelson 5834 Coroner	Sandpoint Ida	12/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 2, 1969	Broten Cemetery	Bonner County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/18/69	Hale Anderson	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 9 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 14 1970 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5594
Local Reg. No. #4
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 041
b. CITY OR TOWN: Sandpoint
LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 041
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 630 Superior

3. NAME OF DECEASED (Type or Print): a. (First) Florence b. (Middle) Mabel c. (Last) Rauch

4. DATE OF DEATH (Month) (Day) (Year): December 2, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 30, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles D. Wells
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Alcesta A. Stukey
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 16 3730 D

17. INFORMANT'S OWN SIGNATURE: Mrs. Bette H. Kelter
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation, acute — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardio-vascular-renal disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Urinary tract infection — 1-2 weeks

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug. 20, 1969, *to* Dec. 2, 1969, *that I last saw the deceased alive on* Dec. 2, 1969, *and that death occurred at* 4:05p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dale G. Coffelt 415 M.D.
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 1/6/70

24a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION-REMOVAL
24b. DATE: 12/6/69
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 12, 1970
REGISTRAR'S SIGNATURE: Hale Anderson

25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 15 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5595
Local Reg. No. #118
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Georgia
b. (Middle): L.
c. (Last): Cox

4. DATE OF DEATH (Month) (Day) (Year): December 4, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 31, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Allen — BIRTHPLACE: Pennsylvania
14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Charles G Cox — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

404X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cardio-vascular renal disease; hypertension — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Senility
Post-op fracture right hip — 2½ mo.

19a. DATE OF OPERATION: Sept. 1969
19b. MAJOR FINDINGS OF OPERATION: Fracture right hip--open reduction
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/10/68, *19*___, *to* Dec. 4, *19*69, *that I last saw the deceased alive on* Nov. 18, *19*69, *and that death occurred at* 12:00 am *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Helen E Peterson Md 415
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 12/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county): Sandpoint — (State): Idaho

DATE REC'D BY LOCAL REG.: 12/11/69
REGISTRAR'S SIGNATURE: Dale Pederson
25. EMBALMER: L. G. Moon, Jr. — LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 5596
Local Reg. No. #123
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: 041 Bonner DEC 22 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Wash. 45
b. COUNTY: Pend Oreille
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Newport 555
d. STREET ADDRESS (If rural, give location): 813 W. 2nd

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alice	May	Carpenter	Dec 8 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Fe	White	Married	Oct 5 1925	44		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Sidney, Mont.	USA

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
Martin Krokom	Myrtle Lovely

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	516 26 1011	A Carpenter	Newport, Wa.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Peritonitis	unknown
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	atrophy adrenal glands	unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-7, 1969, *to* 12-8, 1969, *that I last saw the deceased alive on* 12-8, 1969, *and that death occurred at* 1:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred E. Marineau 327 MD	Sandpoint, Ida	12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12/8/69	Sherman Funeral Home	Newport, Wa. 99156

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/19/69	Helen Pedersen	R. D. Sherman	QL749

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Sherman Funeral Home

DEC 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5597
Local Reg. No. # 120
Reg. Dist. No.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 29 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 417 Michigan

3. NAME OF DECEASED (Type or Print): a. (First) Hurschell b. (Middle) c. (Last) Weaver

4. DATE OF DEATH (Month) (Day) (Year): December 10, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 13, 1899

9. AGE (In years last birthday): 69 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chef and manager 26

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cornelius S. Weaver BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Emma Jane Powell BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 519 01 1144 A

17. INFORMANT'S OWN SIGNATURE: Mrs. Hurschell Weaver ADDRESS:

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Barry D. Nelson SSS (Degree or title): Coroner

23b. ADDRESS: Sandpoint Idaho

23c. DATE SIGNED: 12/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: Dec 13, 1969

24c. NAME OF CEMETERY OR CREMATORY: Moon Crematory

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 12/12/69

REGISTRAR'S SIGNATURE: Nola Nelson

25. EMBALMER: L. G. Moon, Jr. LICENSE NO.: E-405

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16, inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 29 1969 AUG 3 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5598
Local Reg. No. #124
Reg. Dist. No.

Certificate of Death

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 090
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Route 2, Box 185 A

3. NAME OF DECEASED (Type or Print)
a. (First): Wilbur
b. (Middle): Curtis
c. (Last): Hayden M.D.

4. DATE OF DEATH (Month) (Day) (Year): December 17, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: November 26, 1905
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician - Surgeon 14
10b. KIND OF BUSINESS OR INDUSTRY: Medicine
11. BIRTHPLACE (State or foreign country): Oregon
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Curtis Marion Hayden — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Georgia Caroline Barr — BIRTHPLACE: Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W W II 4
16. SOCIAL SECURITY NO.: 538 07 6382
17. INFORMANT'S OWN SIGNATURE: Juanita A. Hayden — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1579

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 10 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 3, 1969, *to* Dec 17, 1969, *that I last saw the deceased alive on* Dec 17, 1969, *and that death occurred at* 6:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joel E. Mouenau 327 MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 12-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 12/29/69
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 2 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 1 2 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5599
Local Reg. No. #5
Reg. Dist. No.

Certificate of Death

RECEIVED
JAN 1 5 1970
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (In this place): Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 034

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 606 N. Ella

3. NAME OF DECEASED (Type or Print)
a. (First): Ralph
b. (Middle): Marvin
c. (Last): Dazey

4. DATE OF DEATH (Month) (Day) (Year): December 18, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: November 16, 1902
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Welch, Indian Terr., Oklahoma
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lemuel T. Dazey — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Florence E. Horn — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 520 09 0291
17. INFORMANT'S OWN SIGNATURE: Mrs Ralph M Dazey — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

492X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Respiratory Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Severe Chronic emphysema progressive years
DUE TO (c): Smoking —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1955, 19__, *to* Dec 18, 1969, *that I last saw the deceased alive on* Dec 18, 1969, *and that death occurred at* 10 25 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 471 MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 1/8/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 1/13/70
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 15 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 12 2006

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5600
Local Reg. No. #3
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091 — JAN 12 1970 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27
b. COUNTY: Sanders 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Noxon
d. STREET ADDRESS (If rural, give location): Box 542

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ralph	R.	Tyler	December 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	July 3, 1896	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Own farm	Ohio	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Tyler	Unknown	Rosa Rush	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES World War I	517 09 9976	✓ Mrs. Ralph Tyler	

4369

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arterio-sclerosis — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-1, 1969, *to* 12-20, 1969, *that I last saw the deceased alive on* 12-20, 1969, *and that death occurred at* 2:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred E. Mavencamp 327 MD	Sandpoint, Idaho	1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 3	Dec 22, 1969	Noxon Cemetery	Noxon Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 8 1970	Dale Pederson	L. G. Moon, Jr.	E-405

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 16 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics JAN 5 1970

State File No. 5601
Local Reg. No. #1
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 09
b. CITY OR TOWN: Sandpoint
LENGTH OF STAY (in this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27
b. COUNTY: Sanders 535
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Noxon
d. STREET ADDRESS (If rural, give location): Box 558

3. NAME OF DECEASED (Type or Print)
a. (First): Henryetta
b. (Middle): Joy
c. (Last): Klakken

4. DATE OF DEATH (Month) (Day) (Year): December 23, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 16, 1904

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Schuyler Hoppins
BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Barbara Ann Hutson
BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 516 14 7880 B

17. INFORMANT'S OWN SIGNATURE: Albert T Klakken
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1958 *to* Dec, 1969, *that I last saw the deceased alive on* Dec 6, 1969, *and that death occurred at* 7P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J Munson 382 M.D
23b. ADDRESS: Sandpoint Ida
23c. DATE SIGNED: 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Dec 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Noxon Cemetery
24d. LOCATION (City, town, or county) (State): Noxon Montana

DATE REC'D BY LOCAL REG.: 1/2/70
REGISTRAR'S SIGNATURE: Dale Pedersen

25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501
FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5602
Local Reg. No. #2
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner
c90 JAN 8 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Priest River
LENGTH OF STAY (In this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Hiway #2 5 mi. E. Priest River

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Montana 27
b. COUNTY: Lake 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Polson
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Bernal b. (Middle) Lee c. (Last) Oylear

4. DATE OF DEATH (Month) (Day) (Year): Dec 24 1969

5. SEX: Male

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct 13 1918

9. AGE (In years last birthday): 51
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendent 17

10b. KIND OF BUSINESS OR INDUSTRY: Saw Mill

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ralph Leland Oylear
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Verlie Webster
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 16 9636

17. INFORMANT'S OWN SIGNATURE: Frank F. Freeman
ADDRESS: Rt 1 Profino, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8129

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Massive accidental trauma
INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fractures & hemorrhage, multiple & extreme
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 06 Hwy 2 4 miles east

21c. (CITY, TOWN, OR TOWNSHIP): Priest River 13090 (COUNTY): Bonner (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 24, 1969 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Head on automobile collision

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Barry D. Nelson 583 (Degree or title) Coroner

23b. ADDRESS: Sandpoint, Idaho

23c. DATE SIGNED: 12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 12/24/69

24c. NAME OF CEMETERY OR CREMATORY: Sherman Funeral Home

24d. LOCATION (City, town, or county) (State): Newport, Wash.

DATE REC'D BY LOCAL REG.: Jan 6 1970

REGISTRAR'S SIGNATURE: Hale Anderson

25. EMBALMER: R. D. Sherman

LICENSE NO.: QL749

FIRM NAME: Sherman Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 13 1970

JAN 14 1970

JAN 15 1970

MAY 25 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in ~~hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.~~

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5603
Local Reg. No. 416
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
DEC 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho 13 b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 15 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042	d. STREET ADDRESS (If rural, give location): 812 Chatham Drive

3. NAME OF DECEASED (Type or Print)	a. (First): Dora	b. (Middle): LaDawn	c. (Last): Settje	4. DATE OF DEATH (Month) (Day) (Year): November 4 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: August 30, 1947	9. AGE (In years last birthday): 22 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Council, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George H. Martin	BIRTHPLACE: Washington	14. MOTHER'S MAIDEN NAME: Jean Beck	BIRTHPLACE: Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 536 42 8707	17. INFORMANT'S OWN SIGNATURE: Dale R. Settje	ADDRESS: Idaho Falls, Idaho	

3910

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pericarditis, myocarditis, acute

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Viral infection suspected

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia, acute, diffuse Hepatitis, acute, focal

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/20/69, 19___, *to* 11/4/69, 19___, *that I last saw the deceased alive on* 11/4/69, 19___, *and that death occurred at* 8:20 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: 262 Kim O Johnson MD (Degree or title)	23b. ADDRESS: Idaho Falls Idaho	23c. DATE SIGNED: 18 Dec 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: 11/5/69	24c. NAME OF CEMETERY OR CREMATORY: Camas Cemetery	24d. LOCATION (City, town, or county) (State): Camas Washington
DATE REC'D BY LOCAL REG.: Dec. 19-1969	REGISTRAR'S SIGNATURE: Anna Bridger	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 25 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5604
Local Reg. No. 419
Reg. Dist. No. 611

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Airplane Enroute from IF, To Denver 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): Handy Cabins, Curtis Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOSEPH	M.	VIGIL	Nov. 26, 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Mexican	Unk	Sept. 16, 1916	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor 00	Potatoe Plant	Ojo Sarco, New Mexico	USA.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Vigil	New Mexico	Tilde Sanchez	New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unk	Unk		Mr. Bell Armijo, (byPhone) New Mexico)

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 9232 Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe burns pulmonary — 1wk
DUE TO (c) and skin

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
XX	Residence 01	Idaho Falls 13/00 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21f. HOW DID INJURY OCCUR?
11-23-69 1:15a.m.		Gas burner explosion in a trailer house

22. *I hereby certify that I attended the deceased from* 11-23-69, 19__, *to* 11-26-, 1969, *that I last saw the deceased alive on* 11-26-, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X [signature] MD	DARREL L. HANSEN, M.D. 502 CLEVELAND ST. IDAHO FALLS, IDAHO 83401 PH. 523-0375	Dec 15, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, Town, or county) (State)
Burial	Dec. 2, 69	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19-1969	[signature]	[signature]	E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5605
Local Reg. No. 417
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Oregon 38 b. COUNTY: Lane 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls — c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eugene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location): 3500 Hilyard

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) ELIZABETH	c. (Last) DIXON	4. DATE OF DEATH (Month) (Day) (Year) Nov. 30, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: June 19, 1893	9. AGE (In years last birthday): 76 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Domestic	11. BIRTHPLACE (State or foreign country): Irvanstown, N. Ireland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Bleakley — BIRTHPLACE: Ireland		14. MOTHER'S MAIDEN NAME: Minnie Wilson — BIRTHPLACE: Ireland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 475 24 4245	17. INFORMANT'S OWN SIGNATURE: Mary E. Jenkins — ADDRESS: Ida. Falls, Ida.		

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Occlusion	1 hour
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary Artery Disease	10 yrs
DUE TO (c)	Arteriosclerosis	20 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-2-, 1969, *to* 11-30-, 1969, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: X [signature] 200 (Degree or title)	23b. ADDRESS: LABREL L. HANSEN, M.D. 502 CLEVELAND ST. IDAHO FALLS, IDAHO 83401 PH. 523-0375	23c. DATE SIGNED: 12/15/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. Cremation 3	24b. DATE: Dec 3, 69	24c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Crematory	24d. LOCATION (City, town, or county) (State): Portland, Oregon
DATE REC'D BY LOCAL REG.: Dec. 19-1969	REGISTRAR'S SIGNATURE: [signature]	25. EMBALMER: [signature]	LICENSE NO.: E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5606
Local Reg. No. 472
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho 13 b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043	d. STREET ADDRESS (If rural, give location): 130 Carol Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) JOSEPH	b. (Middle) EDWARD	c. (Last) HEBERT	4. DATE OF DEATH (Month) (Day) (Year) Dec. 1, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Mar 19, 1923	9. AGE (In years last birthday): 46 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Atomic~~ Representative 08	10b. KIND OF BUSINESS OR INDUSTRY: A.E.C.	11. BIRTHPLACE (State or foreign country): Emmett, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Fernand Hebert,	BIRTHPLACE: Canada	14. MOTHER'S MAIDEN NAME: Clara Kardong,	BIRTHPLACE: Minnesota	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II 4	16. SOCIAL SECURITY NO.: 536 16 5265	17. INFORMANT'S OWN SIGNATURE: Carol V. Hebert	ADDRESS: IF, Ida.	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1541

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Metastatic adenocarcinoma of the Rectum	7 mos
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Rectal Adenocarcinoma	18 mos
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	peritonitis lower abdomen	2 days

19a. DATE OF OPERATION: July 1969	19b. MAJOR FINDINGS OF OPERATION: Recurrent Rectal Carcinoma (in Salt Lake City)	20. AUTOPSY? Yes ☒ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 15, 1969 *to* Dec 1, 1969, *that I last saw the deceased alive on* Dec 1, 1969, *and that death occurred at* 3:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: M. Hutton 515	(Degree or title): M.D.	23b. ADDRESS: 1555 So Blvd Idaho Falls, Idaho	23c. DATE SIGNED: Dec 8-69
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Dec. 5, 69	24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho
DATE REC'D BY LOCAL REG.: Dec 17-1969	REGISTRAR'S SIGNATURE: Anna Bridger	25. EMBALMER: [signature]	LICENSE NO.: E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

FEB 6 1973

MAY 0 8 2012

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5607
Local Reg. No. 413
Reg. Dist. No. 676

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 012

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 3966 1st Street

3. NAME OF DECEASED (Type or Print): a. (First) Della b. (Middle) Delretta c. (Last) Alice Cook

4. DATE OF DEATH (Month) (Day) (Year): December 2 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 27, 1889

9. AGE (In years last birthday): 80
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Layton, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Henry Hodson
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Margaret Adams
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Not Available

17. INFORMANT'S OWN SIGNATURE: Glenn Heath
ADDRESS: Idaho Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Multiple internal injuries — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): 04

21c. (CITY, TOWN, OR TOWNSHIP): Idaho Falls (13101) (COUNTY): Bonneville (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12 1 1969 7:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Hit by a pick up -

22. *I hereby certify that I attended the deceased from* 1 Dec, 1969 *to* 2 Dec, 1969, *that I last saw the deceased alive on* 2 Dec, 1969, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M. Hatch M.D.

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: 10 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/6/69

24c. NAME OF CEMETERY OR CREMATORY: Ammon Cemetery

24d. LOCATION (City, town, or county): Ammon (State): Idaho

DATE REC'D BY LOCAL REG.: Dec. 16-1969

REGISTRAR'S SIGNATURE: Anna Rudy

25. EMBALMER: Ralph M. Wood Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 24 1969

JAN 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 30 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5608
Local Reg. No. 411
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 16 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 30 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1764 Charlene Street

3. NAME OF DECEASED (Type or Print): a. (First) Ida; b. (Middle) Mae; c. (Last) Amundson

4. DATE OF DEATH (Month) (Day) (Year): December 4, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Jan 12, 1894

9. AGE (In years last birthday): 75
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ole Johnson
BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Hannah Herum
BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 476-36-4372 A

17. INFORMANT'S OWN SIGNATURE: Paul J Amundson
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

203X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Multiple Pathologic fracture — 3-4 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 67 *to* 4 Dec, 1969, *that I last saw the deceased alive on* 4 Dec 69, *and that death occurred at* 7:30 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dr. D. C. Hoddard MD

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 8 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: Dec. 8, 1969

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill

24d. LOCATION (City, town, or county) (State): Wells, Minnesota

DATE REC'D BY LOCAL REG.: Dec. 13-1969

REGISTRAR'S SIGNATURE: Emma Budge

25. EMBALMER: Leo A Williams

LICENSE NO.: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5609
Local Reg. No. 419
Reg. Dist. No. 616

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN (This place): 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby (rural)
d. STREET ADDRESS (If rural, give location): Rte. #2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDMOND	MARION	BARON	Dec. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 21, 1894	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farm	Hyrum, Utah.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Baron	England	Mary Ann Buckley	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-36-9013	Victor Baron	Rigby, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of prostate — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with metastases
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-24, 1969, *to* Dec. 7, 1969, *that I last saw the deceased alive on* Dec. 6, 1969, *and that death occurred at* 6:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thos Baron MD 210	M.D.	Idaho Falls, Idaho.	Dec.9,1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec.11,1969	Fielding Memorial	Idaho Falls, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19-1969	Anna Rudgen	Bruce A. Eckersell Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5610
Local Reg. No. 414
Reg. Dist. No. 616

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (In this place) Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1998 Curtis Ave 000	d. STREET ADDRESS (If rural, give location) 1998 Curtis Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Jack	b. (Middle) King	c. (Last) Gordon	4. DATE OF DEATH (Month) (Day) (Year) December 8 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 14, 1888	9. AGE (In years last birthday) 80 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber 08	10b. KIND OF BUSINESS OR INDUSTRY AEC Maintance Dept.	11. BIRTHPLACE (State or foreign country) Arizona	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not Available	BIRTHPLACE Not Available	14. MOTHER'S MAIDEN NAME Not Available	BIRTHPLACE Not Available	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) WW 1 3	16. SOCIAL SECURITY NO. 531 03 6386A	17. INFORMANT'S OWN SIGNATURE Elsie M. Gordon	ADDRESS

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Previous C.V.A. —

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral insufficiency —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1969, *to* 11-14, 1969, *that I last saw the deceased alive on* 11-14, 1969, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE Hoyt B. Woolley 641 (Degree or title) M.D.	23b. ADDRESS 195 So Skyline Idaho Falls, Idaho	23c. DATE SIGNED 12-15-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/10/69	24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	24d. LOCATION (City, town, or county) Idaho Falls (State) Idaho
DATE REC'D BY LOCAL REG. Dec. 16-1969	REGISTRAR'S SIGNATURE Anna Bridges	25. EMBALMER Ralph M. Wood Ralph M. Wood	LICENSE NO. 413

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 1 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5611
Local Reg. No. 415
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 31 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1248 South Blvd. (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1248 South Blvd.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY	ELMA	KELLER	Dec. 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	July 21, 1880	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Domestic	Green City, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Davis	Ohio	Fanny Pfeiffer,	Green City, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 28 4162	Robert Emmett Keller	Ida. Falls, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease 4 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12/5, 1969, to 12/8, 1969, *that I last saw the deceased alive on* 12/8, 1969, *and that death occurred at* 5:20 PM m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	[signature]	12/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 11, 69	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 17-1969	[signature]	[signature]	E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5612
Local Reg. No. 420
Reg. Dist. No. 611

BIRTH NO.

RECEIVED
DEC 24 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Irwin
c. LENGTH OF STAY (in this place): min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): X 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 100
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Irwin
d. STREET ADDRESS (If rural, give location): General Delivery (Box 211)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RUSSELL	OLIVER	McBRIDE	Dec. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Dec. 11, 1899	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	Farming	Hyrum, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Alvin McBride	Unknown	Marie Danielson	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW 1 3	518-14-2606	Ethel McBride	Box 211 Irwin, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3950

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Stenosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rheumatic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1965 *to* Dec 11, 1969 *that I last saw the deceased alive on* Dec 8, 1969, *and that death occurred at* 11:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron T. Weeks 55	M.D.	1585 So. Blvd. Idaho Falls	12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1969	Irwin	Irwin Bonneville Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19-'69	Emma Bradfield	Bruce A. Eckersell Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-6302

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5613
Local Reg. No. 421
Reg. Dist. No. 611

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ucon (rural)
LENGTH OF STAY (In this place) 33 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1 1/2 Mi. S. of Ucon 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville 100
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ucon (rural)
d. STREET ADDRESS (If rural, give location) 1 1/2 Mi. S. of Ucon

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE b. (Middle) ADAMS c. (Last) RUMSEY

4. DATE OF DEATH (Month) (Day) (Year): Dec. 11, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 19, 1886

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheep & cattle 04

10b. KIND OF BUSINESS OR INDUSTRY: ranching

11. BIRTHPLACE (State or foreign country): Malad, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Bradley Rumsey
BIRTHPLACE: Afton, Iowa

14. MOTHER'S MAIDEN NAME: Matilda Adams
BIRTHPLACE: Lehi, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-14-4915

17. INFORMANT'S OWN SIGNATURE: Edith Rumsey
ADDRESS: Rte.#1 Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardio-Vascular-Renal Disease — 8 Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 19 64, *to* Dec 11, 19 69, *that I last saw the deceased alive on* March 4, 19 68, *and that death occurred at* 12:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Clifford B. Rigby M D

23b. ADDRESS: Idaho Falls, Idaho.

23c. DATE SIGNED: Dec. 17/1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 15, 1969

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Dec. 19-'69

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Bruce A. Eckersell
LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 6 1970 Bureau of Vital Statistics

State File No. 5614
Local Reg. No. 424
Reg. Dist. No. 616

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 100
a. STATE: Idaho
b. COUNTY: Bonnneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route #3 Box 290

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	HENRY	CRUMLEY	Dec. 12, 69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Nov. 26, 83	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer, retiree 054	Self	Belton, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Crumley,	Ohio	Barbra Barr	P.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 42 7823 A	Ethie May Crumley	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 4109

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary thrombosis	3 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	arteriosclerosis	
DUE TO (c)	generalized	10 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* 12-12-69, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John S Hatch 210	MD	Idaho Falls	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 15, 69	Rose Hill Cemetery	Idaho Falls, ; Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 31-1969	Anna Bridges	Bill Sullivan	E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

JAN 6 1970

APR 1 1970

JUL 2 5 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5615
Local Reg. No. 422
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 939 Quincy

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Montana
b. COUNTY: Beaverhead
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lima
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Cecil b. (Middle) F. c. (Last) Wetmore

4. DATE OF DEATH (Month) (Day) (Year): December 13 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 5, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher
10b. KIND OF BUSINESS OR INDUSTRY: Ranching
11. BIRTHPLACE (State or foreign country): Silver Star, Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry C. Wetmore — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Carrie Bosworth — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 517 36 5419A
17. INFORMANT'S OWN SIGNATURE: Over telephone from daughter (Marjorie Walker) — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — years
DUE TO (c): generalized

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1967, to 13 Dec, 1969, that I last saw the deceased alive on 5 Dec, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE: D. Hoddard Wood (Degree or title)
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 23 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/14/69
24c. NAME OF CEMETERY OR CREMATORY: Dillon Cemetery
24d. LOCATION (City, town, or county): Dillon (State): MONTANA

DATE REC'D BY LOCAL REG.: Dec. 31-1969
REGISTRAR'S SIGNATURE: Irma Bridges
25. EMBALMER: Ralph M. Wood — Ralph M. Wood
LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5616
Local Reg. No. 432
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
JAN 22 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY (01) Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hsopital (043)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho (13)
b. COUNTY Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 194 10th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JENNIE	E.	KRAUSE	Dec. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Oct. 30, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)	Domestic	Frontier, Wyo	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Wakkila,	Finland	Lisi Frantila,	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 30 7151A	C. G. Krause	194 10th St.

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic heart disease with myocardial infarction and conjestive failure.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bursitis of shoulder.

INTERVAL BETWEEN ONSET AND DEATH: one mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		IDAHO FALLS, BONNEVILLE, IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9-13, 1951, to 12-14, 1969, that I last saw the deceased alive on 12/13, 1969, and that death occurred at 12:25a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
394 C. T. Sullivan	798 South Blvd. IdahoFalls, Id.	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 17, 69	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 14-1970	Anna Rudges	C. T. Sullivan	E 387

FIRM NAME: Buck-Sullivan Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5617
Local Reg. No. 429
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): 435 Cleveland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
AUGUST	WILBURT	OSWALD	Dec. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	1 July 1912	57	5 / 13	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Contractor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
August G. Oswald	Payson, Utah	Zoe Alaline Mill	Schaller, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-05-6446
17. INFORMANT'S OWN SIGNATURE: Mrs. A. W. Oswald ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4310 Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Essential Hypertension — 2 years
DUE TO (c) Obesity — 1 year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5 Dec 69 to 14 Dec 1969, that I last saw the deceased alive on 14 Dec 69, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] Haddock MD	Idaho Falls, Idaho	22 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	17 Dec 1969	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 7-1970	Irma Rudge	Fred A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 17 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5618
Local Reg. No. 423
Reg. Dist. No. 670

BIRTH NO.

RECEIVED
JAN 6 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 310 South Capital

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MATTIE	MABLE	BOWMAN	Dec. 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced	Aug. 22, 1906	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOusewife 01	Domestic	Shelton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Barnes	England	Mary Cleverly	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Mrs Linus W. Bowman	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 1884 Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 10 months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Generalized
DUE TO (c) metastasis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* month 1969 *to* 14 Dec 1969 *that I last saw the deceased alive on* 16 Dec 1969 *and that death occurred at* 4:00 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
503 W. Hollenbeck MD	Idaho Falls, Idaho	26 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rurial	Dec. 18, 69	Ririe-Shelton Cmetery	Ririe, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 31-'69	Emma Budge	Buck Sullivan	E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5619
Local Reg. No. 426
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls c. LENGTH OF STAY (In this place) 24 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LDS Extended Care Unit 042	d. STREET ADDRESS (If rural, give location) 1246 Sage Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) Viola	b. (Middle) Clifford	c. (Last) Maxfield	4. DATE OF DEATH (Month) (Day) (Year) December 18 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH October 29, 1885	9. AGE (In years last birthday) 84 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Butlerville, Utah	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Neri Butler	BIRTHPLACE Indiana	14. MOTHER'S MAIDEN NAME Mary McGhie	BIRTHPLACE Utah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 529 58 2722A	17. INFORMANT'S OWN SIGNATURE [signature]	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1519

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH 18 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-12, 1954, *to* 12-18, 1969, *that I last saw the deceased alive on* 12/18, 1969, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23a. SIGNATURE 104 [signature] (Degree or title)	23b. ADDRESS IDAHO FALLS, IDAHO 83401	23c. DATE SIGNED 1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE 12/22/69	24c. NAME OF CEMETERY OR CREMATORY Grant Cemetery	24d. LOCATION (City, town, or county) (State) Grant Jefferson Co. Idaho
DATE REC'D BY LOCAL REG. Jan. 10-1970	REGISTRAR'S SIGNATURE [signature]	25. EMBALMER Ralph M. Wood [signature]	LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5620
Local Reg. No. 433
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
JAN 22 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 330
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Thornton,
d. STREET ADDRESS (If rural, give location) R#1 Idaho

3. NAME OF DECEASED (Type or Print) a. (First) Peter b. (Middle) M c. (Last) Jorgensen

4. DATE OF DEATH (Month) Dec (Day) 20 (Year) 1969

5. SEX Male
6. COLOR OR RACE Cac
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb 10, 1901
9. AGE (In years last birthday) 68 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Skouby Denmark
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ola Jorgensen BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Maren Sorensen BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-42-9570
17. INFORMANT'S OWN SIGNATURE Letha F Jorgensen ADDRESS Rt 1 Box 89 Thornton Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 485X Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH ~~[illegible]~~ hours

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Early bronchopneumonia 12 "

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatic Valvular disease

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE W L Nielsen 390 MD (Degree or title)
23b. ADDRESS Idaho Falls
23c. DATE SIGNED 1-9-70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE Dec 23 1969
24c. NAME OF CEMETERY OR CREMATORY Firth
24d. LOCATION (City, town, or county) Firth, Bingham (State) Idaho

DATE REC'D BY LOCAL REG. Jan. 15 1970
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Gary L. Walder
LICENSE NO. E444

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5621
Local Reg. No. 425
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 22 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 450 East 24th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Howard	Wilford	Anderson	Dec. 24 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	August 17, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stockman & Trucker 04	Livestock & Trucking	Taylor, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christian Anderson	Utah	Martha Maria Christensen	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 34 7902A	Grace W Andersen	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Thrombosis 4337	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	cerebral arteriosclerosis	3 weeks
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	pneumonia, Carcinoma of prostate	4 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 10, 1966, *to* Dec 24, 1969, *that I last saw the deceased alive on* Dec 24, 1969, *and that death occurred at* 11:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron T Weeks MD 556	Idaho Falls, Idaho	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12/27/69	Hillcrest Cemetery	Shelley Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 31-1969	Emma Rudges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5622
Local Reg. No. 431
Reg. Dist. No. 610

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 — JAN 13 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 8 Mo.
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LDS Nursing Home 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony, Idaho
d. STREET ADDRESS (If rural, give location): 510 West Main

3. NAME OF DECEASED (Type or Print)
a. (First): THOMAS
b. (Middle): JESSE
c. (Last): FENTON

4. DATE OF DEATH (Month) (Day) (Year): Dec 24, 1969

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: March 5, 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer and Farmer
10b. KIND OF BUSINESS OR INDUSTRY: 04
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Fenton — BIRTHPLACE: Salt Lake City, Utah
14. MOTHER'S MAIDEN NAME: Eliza West — BIRTHPLACE: Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-16-0367A
17. INFORMANT'S OWN SIGNATURE: X Russel Fenton — ADDRESS: St. Anthony, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarc of Colon — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls Ida
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-17, 1969, *to* Dec 24, 1969, *that I last saw the deceased alive on* Dec 23, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Hansen MD 200
23b. ADDRESS: Idaho Falls Ida
23c. DATE SIGNED: 12-29 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 30 Dec 69
24c. NAME OF CEMETERY OR CREMATORY: City Cemetery
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: Jan. 4-1970
REGISTRAR'S SIGNATURE: Anna Bridger
25. EMBALMER: M. D. Hansen — LICENSE NO. E-354
FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5623
Local Reg. No. 438
Reg. Dist. No. 610

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 JAN 13 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LDS Nursing Home 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jefferson 26
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mud Lake- Terreton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	INA	LOU	DRIVER ARMSTRONG	Dec 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Divorced	Aug 23, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Dublin, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Solomon Driver	Unknown	Addie Belle Cartwright	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		L. E. Armstrong	Terreton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Arteriosclerotic Heart Disease	2 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized Arteriosclerosis	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Osteo Arthritis	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12 June, 1969, to Dec 26, 1969, *that I last saw the deceased alive on* Dec. 22, 1969, *and that death occurred at* 12:10 AM., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Asael Hall, 522	M.D.	Rigby, Idaho	31 Dec. 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	30 Dec 69	Dubois Cemetery	Dubois, Jefferson, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 4-70	Anne Bridges	M. D. Hansen	E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5624
Local Reg. No. 427
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JAN 13 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this city or town):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 155 West 16th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 155 West 16th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
THOMAS	*	FOX	Dec. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 7, 1879	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railroad Ret. 10	Union Pacific	Rome, Italy	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
January Ficca	Italy	Maria Unk.	Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	712 07 7959A	Mary J. Fox	Ida. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arterioschlerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-3-67 *, 19____, to* 12-27-69 *, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Milton T. Rees M.D.	148 N. Corner Ave,	1-6-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	30 Dec. 69	Rose Hill Cemetery	Idaho Falls	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 10 - 1970	Anna Rudgen	Rice Sullivan	E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 11 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5625
Local Reg. No. 434
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JAN 22 1970

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 7 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Nursing Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route # 1 Box 11

3. NAME OF DECEASED (Type or Print): a. (First) Ruth b. (Middle) Marie c. (Last) Labrum

4. DATE OF DEATH (Month) (Day) (Year): December 30 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 26, 1938

9. AGE (In years last birthday): 31
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis J. Walker
BIRTHPLACE: Montana

14. MOTHER'S MAIDEN NAME: Florence Alena Dutton
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518 66 8254

17. INFORMANT'S OWN SIGNATURE: X Ronald L. Labrum
ADDRESS: Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension — 2yrs.
DUE TO (c): Diabetes mellitus — 5yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1969, to Dec 30, 1969, *that I last saw the deceased alive on* Nov 15, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: David N. Smith M.D. (Degree or title)

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: 1/9/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 1/3/70

24c. NAME OF CEMETERY OR CREMATORY: Ucon Cemetery

24d. LOCATION (City, town, or county) (State): Ucon, Idaho

DATE REC'D BY LOCAL REG.: Jan 16, 70

REGISTRAR'S SIGNATURE: Anna Rudyer

25. EMBALMER: Ralph M. Wood Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5626
Local Reg. No. 429
Reg. Dist. No. 6/0

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls'
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1405 9th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VERNON	LEROY	MILLER	Dec. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 20, 1924	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supervisor 26	Power Plant	Cove, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Miller	Kansas	Laura Kossack	Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 4	518 20 1840	Mrs. Vernon L. Miller	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7341

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Disseminated Lupus Erythematosis — INTERVAL BETWEEN ONSET AND DEATH: 2 + years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Hypertensive Cardiovascular Disease 27 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-9, 1967, *to* 12-31, 1969, *that I last saw the deceased alive on* 12-31, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
* 546	Idaho Falls, Idaho	1/6/70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jan 3, 1969	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 10 - 1970	Irma Bridges	Buck Sullivan	E387

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Buck-Sullivan Funeral Home

JAN 14 1970

APR 3 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 25 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 30 1982

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5627
Local Reg. No. 57-69
Reg. Dist. No. 100

RECEIVED
Bureau of Vital Statistics
JAN 6 1970

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (In this place): 18 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home on Camp Nine Road

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Camp Nine Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLIFFORD	ALLEN	MILLER	December 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	July 13, 1951	18				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	High School	Bonners Ferry, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles C. Miller	Glenrock, Wyoming	Ruth Bishop	Glenrock, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Joe L. Miller	1535 14th Ave Seattle

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

955X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Penetrating bullet wound of chest — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Massive destruction of heart
DUE TO (c) Hemothorax, Left, 2000.0 CC

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
2 Suicide	Residence 31	13110 Boundary Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
12	19	69	12:30 PM		Gunshot wound

22. *I hereby certify that I attended the deceased from* Investigation, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 12:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Callahan	Coroner	P O Box 302 Bonners Ferry Ida	1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/23/69	Grandview Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 4, 1970	Constance Stone	Emile W. Dion	E-536

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 6 1970

APR 12 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JAN 6 1970 Bureau of Vital Statistics

State File No. 5628
Local Reg. No. 55-69
Reg. Dist. No. 100

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Community Restorium, Route #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MAE	(NONE)	HEATHERS	December 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Feb. 20, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Homemaking	Uniacke, Nova Scotia	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Micheal Lade	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	535-12-3793-9	Norman Heathers	Naples, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	CHF 4379	24 hrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral AS	unk
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes	10+ yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
/		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
/ / m.		

22. *I hereby certify that I attended the deceased from* Nov 69 *to* Dec 28 19 69 *that I last saw the deceased alive on* 12/25/69 *and that death occurred at* 9 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Bonners Ferry	12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/30/69	Grandview Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 2, 1970	[signature]	[signature]	E-453

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 5629
Local Reg. No. 56-69
Reg. Dist. No. 100
BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boundary JAN 6 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
LENGTH OF STAY (In this place) 1 mo 6 das
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Bounda ry b. COUNTY Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) P. O. Box #791

3. NAME OF DECEASED (Type or Print) a. (First) ESTELLA b. (Middle) MAY c. (Last) WILEMAN
4. DATE OF DEATH (Month) (Day) (Year) December 29, 1969
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb. 17, 1892
9. AGE (In years last birthday) 77
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Homemaking
11. BIRTHPLACE (State or foreign country) West Newton, Pa.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Grant Willard BIRTHPLACE Madison, Pa.
14. MOTHER'S MAIDEN NAME Ella Neff BIRTHPLACE Madison, Pennsylvania
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 512-09-6076-D
17. INFORMANT'S OWN SIGNATURE Mrs Luella Holmes ADDRESS Bonners Ferry Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
1621
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer of Lung — INTERVAL BETWEEN ONSET AND DEATH 3 MO
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/69, 19__, to 12/29, 19 69, that I last saw the deceased alive on 12/28, 1969 and that death occurred at 2 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Bonners Ferry Ida
23c. DATE SIGNED 12/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 12/31/69
24c. NAME OF CEMETERY OR CREMATORY Cheney Funeral Chapel
24d. LOCATION (City, town, or county) Fort Scott (State) Kansas

DATE REC'D BY LOCAL REG. Jan. 2, 1970
REGISTRAR'S SIGNATURE Loretta Stone
25. EMBALMER
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service FORM DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5630
Local Reg. No. 58-69
Reg. Dist. No. 100

BIRTH NO.

RECEIVED
JAN 14 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary (ID)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Boundary (ID)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): P. O. Box #268

3. NAME OF DECEASED (Type or Print): a. (First) HELEN; b. (Middle) DOROTHY; c. (Last) FOUST

4. DATE OF DEATH: (Month) December (Day) 30, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 31, 1888

9. AGE (In years last birthday): 81
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Mankato, Minnesota

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Detchman
BIRTHPLACE: Russia

14. MOTHER'S MAIDEN NAME: Katherine Kintze
BIRTHPLACE: Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 518-60-4860

17. INFORMANT'S OWN SIGNATURE: Usher Foust
ADDRESS: Bonners Ferry, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Hypertension — Yes

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ____, 19 60 to 12/30, 19 69, that I last saw the deceased alive on 12/30, 19 69, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE: Edward [illegible] 153 (Degree or title)
23b. ADDRESS: Bonners Ferry Ida
23c. DATE SIGNED: 1/7/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/3/70
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: Jan. 12, 1970
REGISTRAR'S SIGNATURE: Myrtle Stone
25. EMBALMER: [illegible]
LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5631
Local Reg. No. 8
Reg. Dist. No. 670

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JAN 8 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 120 Butte
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Howe
c. LENGTH OF STAY (In hospital) 4 mons
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Simplot Farms, Inc. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Butte 120.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Howe
d. STREET ADDRESS (If rural, give location) Simplot Farms, Inc.

3. NAME OF DECEASED (Type or Print)
a. (First) MANUEL
b. (Middle) ENRIQUEZ
c. (Last) DAVILA, JR.

4. DATE OF DEATH (Month) (Day) (Year) December 13, 1969

5. SEX Male
6. COLOR OR RACE Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH Sept. 9, 1966
9. AGE (In years last birthday) 3 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Logan, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Manuel Davila, Sr. — BIRTHPLACE Asserton, Texas
14. MOTHER'S MAIDEN NAME Elizabeth Sanchez — BIRTHPLACE Brownville, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Manuel P. Davila Sr. — ADDRESS Howe, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

890X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suffocation by smoke — INTERVAL BETWEEN ONSET AND DEATH 20 mins.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01
21c. (CITY, TOWN, OR TOWNSHIP) Howe 13120 — (COUNTY) Butte — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-13-69 5:00p m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? House fire

22. *I hereby certify that I attended the deceased from* XX As Coroner only-Did not see alive *, 19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at* 5:20p *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 583 4 (Degree or title) Butte Co. Coroner
23b. ADDRESS Arco, Idaho
23c. DATE SIGNED 12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-16-69
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Arco, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 26-1969
REGISTRAR'S SIGNATURE Betty J. Marvel
25. EMBALMER [signature]
LICENSE NO. E-457

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5632
Local Reg. No. 9
Reg. Dist. No. 670

Certificate of Death

STATE OF IDAHO

RECEIVED
JAN 8 1970
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 120 Butte
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Butte 120
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moore (Rural)
d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First) MAUDE
b. (Middle) BERNIECE
c. (Last) BUXTON

4. DATE OF DEATH (Month) (Day) (Year) December 31, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Nov. 7, 1903
9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Driggs, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Stanley Brooks Fairbanks — BIRTHPLACE Utah Pangutich
14. MOTHER'S MAIDEN NAME Mary Rose Buetler — BIRTHPLACE Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-58-4440
17. INFORMANT'S OWN SIGNATURE C Brooks Buxton — ADDRESS Arco, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*	(a) Arteriosclerotic Heart Disease	10 yrs.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*	~~DUE TO~~ (b) Goiter, Simple Recurrent	10 yrs.
	DUE TO (c) Peripheral edema, severe	3 mo
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Anemia,	3 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1965, *to* Dec. 31, 1969, *that I last saw the deceased alive on* Dec 31, 1969, *and that death occurred at* 9:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE 031 R. F. Barter (Degree or title)
23b. ADDRESS Arco, Ida
23c. DATE SIGNED 1-6-70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1-3-70
24c. NAME OF CEMETERY OR CREMATORY Lost River
24d. LOCATION (City, town, or county) (State) Moore, Idaho

DATE REC'D BY LOCAL REG. Jan. 6, 1970
REGISTRAR'S SIGNATURE Betty J. Marvel
25. EMBALMER C. H. Marvel
LICENSE NO. E-457

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 18 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

DEC 23 1969

Bureau of Vital Statistics

State File No. 5633
Local Reg. No. 590
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 56 Ord Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 56 Ord Blvd.

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE b. (Middle) Q. c. (Last) McFARLAND

4. DATE OF DEATH: (Month) 11 (Day) 27 (Year) 69

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 12, 1900

9. AGE (In years last birthday): 69
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rail Road (Telegraph)

10b. KIND OF BUSINESS OR INDUSTRY: Telegrapher

11. BIRTHPLACE (State or foreign country): Ogden, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William McFarland
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mary Aldus
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 712-01-8145

17. INFORMANT'S OWN SIGNATURE: Katherine McFarland
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Organic Heart disease — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with aortic Stenoses — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

3959

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5-2-69 *, 19____, to* 11-27-69 *, 19____, that I last saw the deceased alive on* 11-24-69 *, 19____, and that death occurred at* 6:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Walter Elder MD (Degree or title)

23b. ADDRESS: 619 So. Canyon, Nampa, Idaho

23c. DATE SIGNED: 12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/1/69

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa Canyon Idaho

DATE REC'D BY LOCAL REG.: Dec. 19, 1969

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: Don A. Simpson

LICENSE NO.: E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 2 4 1969

JUL 1 5 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 2 8 1977
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. AUG 7 1979
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

SEP 1 2 1984

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5634
Local Reg. No. 607
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
d. STREET ADDRESS (If rural, give location): South of City

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Carrie	Alice	Judy	Dec.	1	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Sept. 29, 1887	82	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	(Butler County) Nebraska	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William O. Marlar	Missouri	Harriet E. Scott	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	—	518-54-4774	Homer W. Judy	Payette

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4857X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Recent CVA

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-10-65, 19___, *to* 12-1-69, 19___, *that I last saw the deceased alive on* 12-1-69, 19___, *and that death occurred at* 5:55P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. J. Gubler MD 250	222 East Elm, Caldwell, Idaho	12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	Dec. 4, 1969	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Mrs Martina Walmsley	Keith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5635
Local Reg. No. 571
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 11 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon ,41
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakley's Nursing Home ,77

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon ,41
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 405 Chicago, St.

3. NAME OF DECEASED (Type or Print): a. (First) Fred b. (Middle) A. c. (Last) Schultz

4. DATE OF DEATH (Month) (Day) (Year): Dec. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Sept. 3, 1883	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
oo		Ripon, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
August Schultz	Germany	Mary Minkie	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Mrs. Walter J. Looney	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO (b)~~ Pneumonia
DUE TO (c) Arteriosclerotic cardio-vascular disease — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Amputation of leg for arteriosclerotic gangrene

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
None	None	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12 Nov, 1964, *to* 1 Dec, 1969, *that I last saw the deceased alive on* 17 Nov, 1969, *and that death occurred at* —— m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S. H. Simpson 473	M.D.	Caldwell	4 Dec 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 4, 1969	Roswell Cemetery	Roswell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 9, 1969	Mrs. Martina Walmsley	Fennell E. Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 1 1 1969
Bureau of Vital Statistics

State File No. 5636
Local Reg. No. 570
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. View Terrace Nursing Home 360	d. STREET ADDRESS (If rural, give location) Rt. # 2,

3. NAME OF DECEASED (Type or Print)	a. (First) Bertha	b. (Middle) Elizabeth	c. (Last) Weber	4. DATE OF DEATH (Month) (Day) (Year)	Dec. 2, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 21, 1884	9. AGE (In years last birthday) 85	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Burns, Kansas	12. CITIZEN OF WHAT COUNTRY? USS	
13. FATHER'S NAME Jacob Oberat	BIRTHPLACE Germany		14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Germany	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-18-7927D		17. INFORMANT'S OWN SIGNATURE George Weber	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: one hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary sclerosis
DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: 1 = Generalized arteriosclerosis 2 = Post CCA

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~19-61~~ 1961, 19__, *to* 12-2, 1969, *that I last saw the deceased alive on* 12-2, 1969, *and that death occurred at* 11:70 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 166 (Degree or title)	23b. ADDRESS Caldwell Ida	23c. DATE SIGNED 12-4-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 5, 1969	24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery	24d. LOCATION (City, town, or county) (State) Caldwell, Idaho
DATE REC'D BY LOCAL REG. Dec. 9, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Kenneth E. Spence	LICENSE NO. E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 11 1969 Bureau of Vital Statistics

State File No. 5637
Local Reg. No. 572
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY CANYON 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) MELBA -RURAL
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION HOME R# 1- MELBA, IDAHO 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO b. COUNTY CANYON 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) MELBA -RURAL
d. STREET ADDRESS (If rural, give location) R# 1

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) ELLERY c. (Last) BERRETT

4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 3, 1969

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED

8. DATE OF BIRTH JUNE 22, 1892

9. AGE (In years last birthday) 77
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY FARMED

11. BIRTHPLACE (State or foreign country) NORTH ODGEN, UTAH

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HAMLET ELLERY BERRETT BIRTHPLACE NO RECORD

14. MOTHER'S MAIDEN NAME NO RECORD BIRTHPLACE NORECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 558-46-0101

17. INFORMANT'S OWN SIGNATURE ADDRESS X Gerald Ray Berrett

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection only *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* FOUND 11:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE Henry E. Wenche 583 4 (Degree or title) M. D. Coroner

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED 12-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 12/6/69

24c. NAME OF CEMETERY OR CREMATORY MELBA CEMETERY

24d. LOCATION (City, town, or county) CANYON (State) IDAHO

DATE REC'D BY LOCAL REG. Dec. 9, 1969

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER

LICENSE NO. E-496

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5638
Local Reg. No. 575
Reg. Dist. No. 360

RECEIVED DEC 12 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Robert	F.	Holmes	Dec. 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Aug. 23, 1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer-Retired	Farming	Texas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William W. Holmes	Texas	Mary Ella Holmes	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-26-0009A	Jennie R. Dawson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: One year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March 15, 1969, *to* Dec 3, 1969, *that I last saw the deceased alive on* Dec 3, 1969 *and that death occurred at* 11:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Caldwell Ida	12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-6-1969	Marsing-Homedale	Homedale Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 11, 1969	Mrs. Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased,
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5639
Local Reg. No. 578
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: CANYON 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: PARKVIEW MANOR 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: ADA 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): STAR
d. STREET ADDRESS (If rural, give location): STAR

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY	ELLEN	KILBURN	DECEMBER 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	WIDOWED	OCTOBER 21, 1875	94		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	BEAVER CITY, NEBRASKA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
EMANNEL VANNORSDEL	NO RECORD	PHOEBE ANN	NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE / ADDRESS
NO	518-54-6881 J1	E. R. Kilburn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebro-vascular accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 2, 1968, *to* Dec 3, 1969, *that I last saw the deceased alive on* Nov 6, 1969, *and that death occurred at* 6:30P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. Hall	MD	Nampa, Idaho	12/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL 3	12/8/69	STAR CEMETERY	STAR, ADA IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15, 1969	Mrs. Martina Walmsley	Marion R. Hilliard	E515

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 4 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5640
Local Reg. No. 573
Reg. Dist. No. 360

RECEIVED
DEC 11 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 142 CANYON	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA c. LENGTH OF STAY (In this place) 1 MONTH	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050	d. STREET ADDRESS (If rural, give location) 723-14 AVENUE SOUTH

3. NAME OF DECEASED (Type or Print) a. (First) EVERETTE	b. (Middle) COLE	c. (Last) MAYNE	4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 3, 1969	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUGUST 3, 1887	9. AGE (In years last birthday) 82 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. RAILROAD MAN 10	10b. KIND OF BUSINESS OR INDUSTRY U.P. RAILROAD	11. BIRTHPLACE (State or foreign country) FONTANELLE, IOWA	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN GILMER MAYNE	BIRTHPLACE NO RECORD	14. MOTHER'S MAIDEN NAME RUTH ATWOOD	BIRTHPLACE NO RECORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 484-16-2972	17. INFORMANT'S OWN SIGNATURE Family Records, By: Tony S. Kroenk	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

535X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hemorrhagic Gastritis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. ~~DUE TO (b)~~ Post Operative Hemorrhage

DUE TO (c) Gastric Resection

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (1) Pneumonia (2) Hepatitis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Poorly functioning old Gastroenterostomy	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 Nov, 1969, *to* 3 Dec, 1969, *that I last saw the deceased alive on* 3 Dec, 1969, *and that death occurred at* 2:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE J R Manzum 322 (Degree or title)	23b. ADDRESS Nampa, Idaho	23c. DATE SIGNED 5 Dec 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 8, 1969	24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	24d. LOCATION (City, town, or county) (State) Nampa, Canyon, Idaho
DATE REC'D BY LOCAL REG. Dec. 9, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Marvin R. Hickkila	LICENSE NO. E 515

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5641
Local Reg. No. 582
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (14)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital (057)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (14)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 908 Chicago St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edgar	Leroy	Oakes	Dec. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Dec. 20, 1891	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Seedman (06)		Caldwell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ralph W. Oakes		Ora Lucas	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	War I 3	518-32-7812 A	Mrs. Edgar L. Oakes	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—		—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
— m.		

22. *I hereby certify that I attended the deceased from* 12/4, 19 69, *to* 12/4, 19 69, *that I last saw the deceased alive on* 12/4, 19 69, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Gerald C. Bateman (034) M.D.	Caldwell, Idaho	12/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 8, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 16, 1969	Mrs. Martin Walmsley	Kenneth E. Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 22 1969

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to ahy one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5642
Local Reg. No. 580
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. View Terrace Nursing Home 360

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 2711 So. Indiana
d. STREET ADDRESS (If rural, give location) Caldwell

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jeannette		Morefield	Dec. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	June 23, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Howard, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	534-24-7482B	L. Morefield	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclevosis — Progressive
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from May 23, 1969, to 5 Dec, 1969, that I last saw the deceased alive on 23 May, 1969 and that death occurred at 7:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Krause 295	M.D	Caldwell, Idaho	17 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Entombment 3	Dec. 8, 1969	Mt. View Mausoleum	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 16, 1969	Mrs. Martina Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5643
Local Reg. No. 577
Reg. Dist. No. 360

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 146
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Nursing Home 296	d. STREET ADDRESS (If rural, give location) Box 352

3. NAME OF DECEASED (Type or Print)	a. (First) Zella Melinda	b. (Middle) Mae	c. (Last) Justis	4. DATE OF DEATH (Month) (Day) (Year) Dec. 7, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow ed	8. DATE OF BIRTH Aug. 7, 1883	9. AGE (In years last birthday) 86 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? USA USA	
13. FATHER'S NAME Tom C. Bowman	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Nancy Unknown	BIRTHPLACE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 490-05-9387 B	17. INFORMANT'S OWN SIGNATURE Julius R. Cobb	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Arteriosclerosis	3 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pneumonia	4 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 5/23/ *, 19* 68 *to* 12/7/ *, 19* 69 *, that I last saw the deceased alive on* 12/6 *, 19* 69 *, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Richard C. Tweyer M.D. 666 (Degree or title)	23b. ADDRESS 619 So. Canyon, Nampa, Idaho	23c. DATE SIGNED 12-9-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec.10,1969	24c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Garden	24d. LOCATION (City, town, or county) (State) Caldwell, Idaho
DATE REC'D BY LOCAL REG. Dec. 12, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER James R. Dakan	LICENSE NO. E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5644
Local Reg. No. 606
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Arizona 03
b. COUNTY: Mohave 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kingman
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Isabella	Crozier	Miller	Dec. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Aug. 6, 1878	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hackberry, Arizona
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Crozier	Ohio	Ida Baker	California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 527-70-1608
17. INFORMANT'S OWN SIGNATURE: Lola F. Ingstrom ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4339

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cerebral vascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Aortic stenosis, bronchopneumonia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes XX No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-30-69, 19____, *to* 12-7-69, 19____, *that I last saw the deceased alive on* 12-7-69, 19____, *and that death occurred at* 2:p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Reed M.D. 379	222 East Elm, Caldwell, Idaho	12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Dec. 9, 1969	Mt. View Cemetery	Kingman, Arizona

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Mrs Martin Walmsley	James R Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5645
Local Reg. No. 576
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 8 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 619 18th Ave. So.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 619 18th Ave. So.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Thomas	Way	Vernon	December 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 20, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Equipment Forman 36	Agriculture	Lebanon, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas A. Vernon	Jackson, Tenn.	Jane McVey	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	543-05-0043	† Mary E. Vernon	Nampa, Idaho

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-1 , 1962 , *to* 12-7- , 1969 , *that I last saw the deceased alive on* 10-23 , 1969 , *and that death occurred at* 9:10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
John C. Wirsch M.D. 56 (Degree or title)	Nampa - Idaho	12-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 10, 1969	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 12, 1969	Mrs. Martin Walmsley	Glen E. Sires	E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 19 1969
Bureau of Vital Statistics

State File No. 5646
Local Reg. No. 584
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa; c. LENGTH OF STAY (In this place): 18 yrs.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 412 - 1st St. No., Ext. 000	d. STREET ADDRESS (If rural, give location): 412 - 1st St. No., Ext.

3. NAME OF DECEASED (Type or Print)	a. (First) PHEOB	b. (Middle) ESSIE	c. (Last) WARD	4. DATE OF DEATH (Month) (Day) (Year) Dec. 7, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Mar. 6, 1887	9. AGE (In years last birthday): 82; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: At Home	11. BIRTHPLACE (State or foreign country): Rushville, Indiana	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William C. Layton	BIRTHPLACE: Indiana	14. MOTHER'S MAIDEN NAME: Cordelia Jane Evans	BIRTHPLACE: Tennessee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-60-3946J	17. INFORMANT'S OWN SIGNATURE: x Robert W Ward	ADDRESS: Bakersfield, California	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Occlusion, Acute

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): Arteriosclerotic Heart Dis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/13, 1969, *to* 11/17, 1969, *that I last saw the deceased alive on* 11/17, 1969, *and that death occurred at* 1:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 23 (Degree or title)	23b. ADDRESS: 214 D Hdq, Nampa Ida	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12/9/69	24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery	24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho
DATE REC'D BY LOCAL REG.: Dec. 18, 1969	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: Jerry S. Krouch	LICENSE NO.: E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 22 1969

MAR 23 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

State File No. 5647
Local Reg. No. 579
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 207 W. Logan

3. NAME OF DECEASED (Type or Print) a. (First) Leslie b. (Middle) Carl c. (Last) Hindberg

4. DATE OF DEATH (Month) (Day) (Year) Dec. 8, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec. 12, 1904

9. AGE (In years last birthday) 64
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book binder 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles A. Hindberg
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Grace Evelyn Gugan
BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-09-0907 A

17. INFORMANT'S OWN SIGNATURE Dora Hindberg ADDRESS Caldwell

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 402X Aortic Aneurism — INTERVAL BETWEEN ONSET AND DEATH Months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sustained Essential Hypertension Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Left Ventricular Hypertrophy

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-8 1969, to 12-8 1969, that I last saw the deceased alive 12-8 1969 5:30 PM, and that death occurred at 5:30 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title) 358

23b. ADDRESS 222 East Logan

23c. DATE SIGNED 12-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 12, 1969

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Dec. 15, 1969

REGISTRAR'S SIGNATURE Mrs. Martena Walmsley

25. EMBALMER Roderick L. Dakan

LICENSE NO. E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 26 1970

NOV 0 8 1991

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5648
Local Reg. No. 610
Reg. Dist. No. 360

Certificate of Death

RECEIVED
DEC 31 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF DEATH (In this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Vale Rural
d. STREET ADDRESS (If rural, give location): Rt. 2 Box 31L

3. NAME OF DECEASED (Type or Print): a. (First) Mervin; b. (Middle) Jack; c. (Last) Bowman

4. DATE OF DEATH (Month) (Day) (Year): December 9, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Sept. 28, 1948
9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Feed Mill
11. BIRTHPLACE (State or foreign country): Ontario, Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mervin Bowman — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Bernice Davis — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): National Guard 6
16. SOCIAL SECURITY NO.: 544-58-4100
17. INFORMANT'S OWN SIGNATURE: Mervin Bowman — ADDRESS: Rt. 2 Box 31L Vale, Oregon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Emboloi

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Subdural hematoma
DUE TO (c): auto wreck

INTERVAL BETWEEN ONSET AND DEATH: 10 days

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 00000
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11 - 29 - 69 m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-29, 1969, *to* 12-9, 1969, *that I last saw the deceased alive on* 12-9, 1969, *and that death occurred at* 10:00 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 425 M.D.
23b. ADDRESS: Caldwell, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 12-12-69
24c. NAME OF CEMETERY OR CREMATORY: Valley View Cemetery
24d. LOCATION (City, town, or county) (State): Vale Oregon

DATE REC'D BY LOCAL REG.: Dec. 30, 1969
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Dean Blatchley
LICENSE NO.: 362

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HIGH FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 2 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5649
Local Reg. No. 581
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma
d. STREET ADDRESS (If rural, give location) Rt. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Effie	M.	Brown	Dec. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Aug. 20, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Buffington	Iowa	Phoebe Pruitt	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-58-9668T	M. L. Brown	Parma R. 1

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5770

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	12 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral Concussion	4 wks.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Systemic Lupus Erythematosus	3 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ____, 19 66 to 9 Dec, 19 69, that I last saw the deceased alive on 9 Dec 1969, 19 69, and that death occurred at 4:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. J. Coulson M.D. 051	Caldwell Idaho	12 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 16, 1969	Mrs. Martin Walmsley	Rodney C. Dakan	E-508

FIRM NAME Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5650
Local Reg. No. 587
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 19 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place): 10 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 903 11th Ave. So.

3. NAME OF DECEASED (Type or Print): a. (First) Edward b. (Middle) O. c. (Last) Stapleton

4. DATE OF DEATH (Month) (Day) (Year): Dec. 9, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 7, 1895

9. AGE (In years last birthday): 74
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Switchman
10b. KIND OF BUSINESS OR INDUSTRY: U.P. Rail Road

11. BIRTHPLACE (State or foreign country): Conway Arkansas

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Henry Stapleton
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Kate Moore
BIRTHPLACE: Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W. I 3

16. SOCIAL SECURITY NO.: 712 05 6397

17. INFORMANT'S OWN SIGNATURE: X Mrs. D. Faith Hallberg
ADDRESS: Portland, Oreg

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2313

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Tumor @ lung root — 2 yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/8/ , 19 69 *to* 12-9-69 , 19 , *that I last saw the deceased alive on* 12/9 , 19 69 *and that death occurred at* 9:12 PM *from the causes and on the date stated above.*

23a. SIGNATURE: Harold W Brown MD (Degree or Title)

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: 12/12/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-13-69

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Canyon County, Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: M. O. Shepherd

FIRM NAME: Shepherd Mortuary

LICENSE NO.: 473

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5651
Local Reg. No. 588
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 19 1969 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1307 E. Washington

3. NAME OF DECEASED (Type or Print) a. (First) Ruth b. (Middle) E. c. (Last) Yoder

4. DATE OF DEATH (Month) (Day) (Year) Dec. 9, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 27, 1912

9. AGE (In years last birthday) 57
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper 19

10b. KIND OF BUSINESS OR INDUSTRY Physicians Office

11. BIRTHPLACE (State or foreign country) Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME N. J. Sheffield
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Salome Nedrow
BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-42-1380

17. INFORMANT'S OWN SIGNATURE X Jean Walston ADDRESS Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 2000 Hamilton cell sarcoma — INTERVAL BETWEEN ONSET AND DEATH 2 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-30-69, 19__, to 12-9-69, 19__, that I last saw the deceased alive on 12-8-69, 19__, and that death occurred at 11:10A m., from the causes and on the date stated above.

23a. SIGNATURE Norma E. Boughner (Degree or title) MD 130

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED 12-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-12-69

24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) Nampa, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 18, 1969

REGISTRAR'S SIGNATURE Mrs Martin Walmsley

25. EMBALMER M. B. Shepherd

LICENSE NO. 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 23 1969 Bureau of Vital Statistics

State File No. 5652
Local Reg. No. 589
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (In this place) months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor Nursing Home 30

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Midland Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Esther	Ellen	Holbert	Dec. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	MAr 31, 1900	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife C1	at home	So. Carolina	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis Pearson	So. Carolina	Climmie McCAbee	So. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	none	from family records by: Jerry S. Brown	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardio respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastatic breast carcinoma
DUE TO (c) Congestive heart failure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September, 1969 *to* Dec. 10, 1969, *that I last saw the deceased alive on* Dec. 1, 1969, *and that death occurred at* 7.30 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S E Lusk, MD	619 So. Canyon Nampa	12/7/1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1969	Kohlerlawn Cemetery	Nampa Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19, 1969	Mrs. Martine Walmsley	Richard W. Mesenbrink	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5653
Local Reg. No. 593
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 528 Almond Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BLANCHE	B.	KEITH	Dec. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	May 15, 1887	82	6	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	At Home	Carbondale, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William W. Bailey	Virginia	Lina Luthey	Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		X Robert B Keith	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

887X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Thrombophlebitis of gastrointestinal tract.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Thrombophlebitis left femoral vein.
DUE TO (c) Fracture, right hip.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic disease of the lung.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10/10/69	Fracture, proximal right femur.	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
XX / /	at home 01	Nampa 13142 Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
10-9-69 1p m.		Patient fell at home

22. *I hereby certify that I attended the deceased from* 10/9/69 *, 19____, to* 10/10/69 *, 19____, that I last saw the deceased alive on* 12/10/69 *, 19____, and that death occurred at* 9:50p *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Ervin B. Bowman, Jr., M.D. 878 (Degree or title)	214-D Holly St., Nampa, ID.	12/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12/13/69	Wilson Cemetery	Owyhee County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 22, 1969	Mrs. Martina Walmsley	Richard W Messenger	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 31 1969 Bureau of Vital Statistics

State File No. 5654
Local Reg. No. 611
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa c. LENGTH OF STAY (In this place) 11 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, 83651
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Nursing Home 296	d. STREET ADDRESS (If rural, give location) Parkview Nursing Home, Lincoln Park

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last): PHOEBE ALTHEREA NEIVIER NELSON

4. DATE OF DEATH (Month) (Day) (Year): Dec. 11. 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
Female	White	Widowed	Aug. 5, 1899	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hyrum A. Neivier	No record	Alice A. Millward	No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-26-2439	Glen S. Siren	Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebro Vascular Hemorrhage	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	ASHD	10 yrs
DUE TO (c)	Diabetes Mellitus	15 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1962, *to* Dec, 1969, *that I last saw the deceased alive on* Dec 11, 1969, *and that death occurred at* 2:05p. *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Graydon O. Crow	115	Nampa Idaho	26 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Dec. 11, 1969	Redwood Memorial Estates	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 30. 1969	Mrs. Martina Walmsley	Glen S. Siren	E 498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 4 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5655
Local Reg. No. 598
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051	d. STREET ADDRESS (If rural, give location) 720 Ithica

3. NAME OF DECEASED (Type or Print)	a. (First) Inez	b. (Middle) Arlene	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) Dec. 11, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 12, 1916	9. AGE (In years last birthday) 53 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Northwood, Iowa	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer Olmstead	BIRTHPLACE Iowa	14. MOTHER'S MAIDEN NAME Cora Dale	BIRTHPLACE Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 480-20-4917	17. INFORMANT'S OWN SIGNATURE Albert W Smith	ADDRESS	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

450X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pulmonary Embolus	1/2 hr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Serous cystadenocarcinoma of Rt Ovary	6 month

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 11 Dec, 1969 *to* 11 Dec, 1969, *that I last saw the deceased alive on* 11 Dec 1969, *and that death occurred at* 11:05 P *m., from the causes and on the date stated above.*

23a. SIGNATURE 051 A L Poulsen M.D. (Degree or title)	23b. ADDRESS Caldwell Idaho	23c. DATE SIGNED 19 Dec 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE Dec. 15, 1969	24c. NAME OF CEMETERY OR CREMATORY Emmett Cemetery	24d. LOCATION (City, town, or county) (State) Emmett, Idaho
DATE REC'D BY LOCAL REG. Dec. 23, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER [signature]	LICENSE NO. E-285

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 26 1970
APR 6 1970
MAY 11 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JUN 9 1970
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5656
Local Reg. No. 605
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 05

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 705 N. 9th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Willard	Jack	Stewart	Dec. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Dec. 10, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Johnstown, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hiram Stewart	Tenn.	Lulu Nelson	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	War I 3	519-28-6388	X Ward S Stewart	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute coronary

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-13-53, 19____, *to* 12-11-69, 19____, *that I last saw the deceased alive on* 12-11-69, 19____, *and that death occurred at* 1:30A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
250 W M Aufderm	222 East Elm, Caldwell, Idaho	12-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 15, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Mrs Martin Welmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5657
Local Reg. No. 591
Reg. Dist. No. 360

69-12309
BIRTH NO.

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF: 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Rt. # 4,

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
KELLY	BUD	SANFORD	Dec. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Infant	Dec. 10, 1969		2	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Kent W. Sanford	Idaho	Judy Vandever	New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Kent Sanford — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7469

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive Heart Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypoplastic Left Ventricle
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-10-, 1969, to 12-12, 1969, that I last saw the deceased alive on 12-12-, 1969, and that death occurred at 4:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Eugene A. Brown, MD (Degree or title)	619 So. Canyon Nampa Ida	12/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/15/69	Hillcrest Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19, 1969	Mrs. Martin Walmsley	Marvin R. Fredricks	E 515

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH--63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 5658
Local Reg. No. 592
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 DEC 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place): 1 month
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 142
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 223 Amity Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BUNJI	(BEN)	YAMADA	Dec. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Oriental	Widowed	Feb. 16, 1883	86	9	26		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 27	Farmer	Fukuoka, Ken, Japan	Japan

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
No Record	No Record	No Record	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-5976	Lilly Ogawa	Caldwell, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonea 342X	1 wk
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Parkensons Disease	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellatus	1 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept 27, 1962, to Dec. 12, 1969, that I last saw the deceased alive on Dec. 12, 1969, and that death occurred at 7:00 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert E. Clay MD 217	619 S. CANYON NAMPA	12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/16/69	Hillcrest Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19, 1969	Mrs. Martina Walmsley	Jerry S. Brooks	E-447

FIRM NAME: Atsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5659
Local Reg. No. 594
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Curtiss Park 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 5

3. NAME OF DECEASED (Type or Print) a.-(First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Rodney	Earl	Peterson	Dec. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	March 21, 1944	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03		Ontario, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
A.O. Peterson	South Dakota	Lucille D. Wallis	South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-48-5990	X A.O. Peterson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

95211

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carbon Monoxide Poisoning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide	Curtis Psrk 32	Caldwell 13141 Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Dec 13 1969 P.M.		

22. *I hereby certify that I attended the deceased from* Inspection Only *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche 533	M. D. Coroner	Nampa, Idaho	12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 16, 1969	Hillcrest Memorial Gardens	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 22, 1969	Mrs. Martina Walmsley		E-285

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 8 1970

APR 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5660
Local Reg. No. 612
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 17 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 650

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 123 Fern

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lola	E.	Triplett	Dec. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Feb. 13, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife 01	At Home	Chester County, Ohio	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Furman Smith	No Record	Elizabeth Mooney	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518 46 2140 B	x N L Triplett	Nampa

4369

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	A Cerebral Vascular Disease with Stroke	2 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12/2/ , 19 69 , to 12/13/ , 19 69 , *that I last saw the deceased alive on* 12/13/ , 19 69 , *and that death occurred at* 8:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Eddy MD 217	Nampa, Idaho	12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-15-69	Hillcrst Memorial Gardens	Canyon County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 30, 1969	Mrs. Martin E Walmsley	M B Shepherd	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 16 1970
APR 19 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

APR 26 2005

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 5661
Local Reg. No. 615
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon — JAN 2 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (In this place) 30 years
d. FULL NAME OF HOSPITAL OR INSTITUTION 1623 4th Street No.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho — b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa 83651
d. STREET ADDRESS (If rural, give location) 1623 4th Street No.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Marion	C.	Anderson	December 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	April 26, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Lorenzo, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew Christenson	Denmark	Amanda Anderson	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-16-1927	Mrs Art Clayton	R#5 Nampa Ida

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Alcohol Intoxication
Symptoms of Delirium Tremens

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Inspection only 19__ to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 10:15 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wenske 583 4 M. D. Coronar	Nampa, Idaho	I2-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 17, 1969	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 31, 1969	Mrs. Martin Walmsley	Glen L. Siren	E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 21 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
DEC 31 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5662
Local Reg. No. 613
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 14 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 812 5th St. North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 812 5th St. North

3. NAME OF DECEASED (Type or Print)
a. (First) Louis
b. (Middle) C.
c. (Last) Murphy

4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 1, 1889
9. AGE (In years last birthday) 80
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Wayne County, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME No Record
BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME No Record
BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 544 26 6079
17. INFORMANT'S OWN SIGNATURE X Blanche M Murphy
ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4412

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Abdominal aortic aneurysm
INTERVAL BETWEEN ONSET AND DEATH 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/4/ *, 19*65*, to* 12/14/ *, 19*69*, that I last saw the deceased alive on* 12/14/ *, 19*69*, and that death occurred at* 8:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 217 (Degree or title)
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-17-69
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. Dec. 30, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER M. B. Shepherd
LICENSE NO. 498

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED DEC 23 1969

Bureau of Vital Statistics

State File No. 5663
Local Reg. No. 595
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital (05)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 3

3. NAME OF DECEASED (Type or Print): a. (First) Otto; b. (Middle) A.; c. (Last) Weick

4. DATE OF DEATH (Month) (Day) (Year): Dec. 14, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 21, 1889

9. AGE (In years last birthday): 80
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer (04)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Graben, Germany

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hermann Weick
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Christina Suess
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-40-2460

17. INFORMANT'S OWN SIGNATURE: Mrs. Otto A. Weick
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Massive Cerebrovascular edusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — indefinite
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19 51 *to* 12-14, 19 69, *that I last saw the deceased alive on* 12-14, 19 69, *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Karl E Kenick (280) — (Degree or title): MD

23b. ADDRESS: 1819 Ellis St Caldwell Idaho

23c. DATE SIGNED: 12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 17, 1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Dec. 22, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Rodney W. Dakan

LICENSE NO.: E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 24 1969

APR 5 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5664
Local Reg. No. 596
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
DEC 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Notus
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Car Train Accident (00)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Box 344

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Paula		Güzman	Dec. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Mexican	Married	Feb. 18, 1934	35		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Kennedy, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Otilia DeLeon	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		x Roger DeLeon	Box 344, Wilder Id.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Laceration of Chest and abdominal injuries

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Car train accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.: Multiple fractures both legs

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Railroad crossing 06	Notus 13140 Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
Dec. 15, 1969 About 11:45 A. M.		Car crossed in front of train

22. *I hereby certify that I attended the deceased from* Inspection only *19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at* 11:45 *m. from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche 583 M. D. Coroner	Nampa, Idaho	12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 19, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 23, 1969	Mrs Martin J Walmsley	Kenneth E Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 4 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5665
Local Reg. No. 609
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
d. STREET ADDRESS (If rural, give location): Route # 5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jessie	Hannah	Martin	Dec. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	June 24, 1890	79	5	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife c/	Retired	Bellevue, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clark Nichols	Illinois	Mamie Drake	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-58-9491	Thomas Martin	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Stroke	6hr
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic vascular disease	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Fractured hip	2d

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1964, *to* Dec, 1969, *that I last saw the deceased alive on* Dec 17, 1969, *and that death occurred at* 5:40 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Karl Reynolds 437 MD	Caldwell Idaho	Dec 29 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-18-1969	Parkview Cemetery	New Plymouth, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Mrs. Martin's Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5666
Local Reg. No. 599
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY 142 CANYON	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE IDAHO b. COUNTY CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA — LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 812-2ND. STREET NORTH 000	d. STREET ADDRESS (If rural, give location) 812-2ND. STREET NORTH

3. NAME OF DECEASED (Type or Print) a. (First) OTILIE	b. (Middle)	c. (Last) DOSTAL	4. DATE OF DEATH (Month) DECEMBER (Day) 16, (Year) 1969	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH FEBRUARY 2, 1885	9. AGE (In years last birthday) 84 — IF UNDER 1 YR. Months 10 Days 14 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 01	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Moravia, Czechoslovakia	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANTONIN SADILEK	BIRTHPLACE Czechoslovakia	14. MOTHER'S MAIDEN NAME FRANCES BLAZEK	BIRTHPLACE Czechoslovakia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S OWN SIGNATURE Joseph Dostal	ADDRESS 13190 Seal Bk Calif. apt 249-K	

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebrovascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized ASHD

DUE TO (c) Congestive failure

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12-16-66	19b. MAJOR FINDINGS OF OPERATION Aortic Aneurysm Abdominal - Replaced	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-5, 1966, *to* Dec 16, 1969, *that I last saw the deceased alive on* Dec 15, 1969, *and that death occurred at* 1:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE Graydon O Gross 115 (Degree or title)	23b. ADDRESS Nampa Ida	23c. DATE SIGNED 19 Dec 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/19/69	24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery	24d. LOCATION (City, town, or county) (State) Nampa Canyon Idaho
DATE REC'D BY LOCAL REG. Dec. 23, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER [signature]	LICENSE NO. E-496

FIRM NAME ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5667
Local Reg. No. 600
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa c. LENGTH OF STAY (In this place) 4 Months	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050	d. STREET ADDRESS (If rural, give location) 1803 7th St. So.

3. NAME OF DECEASED (Type or Print)	a. (First) Henry	b. (Middle) M.	c. (Last) Knapp	4. DATE OF DEATH (Month) (Day) (Year) Dec. 16, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 2, 1903	9. AGE (In years last birthday) 66 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Washington	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME C. R. Knapp	BIRTHPLACE No Record	14. MOTHER'S MAIDEN NAME Clara M. Stewart	BIRTHPLACE Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 544 03 7159	17. INFORMANT'S OWN SIGNATURE x Docia Knapp	ADDRESS Nampa	

4123

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) *This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) arteriosclerotic Ht disease	2 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis obliterans	3 yrs
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 7/25/ *, 19* 69 *to* 12/16/ *, 19* 69 *, that I last saw the deceased alive on* 12/16/ *, 19* 69 *and that death occurred at* 9:40A *m., from the causes and on the date stated above.*

23a. SIGNATURE Robert E. Hay MD 217 (Degree or title)	23b. ADDRESS Nampa, Idaho	23c. DATE SIGNED 12/22/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-19-69	24c. NAME OF CEMETERY OR CREMATORY Koblerlawn Cemetery	24d. LOCATION (City, town, or county) (State) Nampa, Idaho
DATE REC'D BY LOCAL REG. Dec. 23, 1969	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Glen S. Siren	LICENSE NO. 498

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5668
Local Reg. No. 597
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1012 Denver

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Phoebe	M. Cashman	Cain	Dec. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Nov. 25, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Edmond, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard P. Cashman	Illinois	Almyra Dickson	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	562-18-4519B	Helen C. Henry	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____ *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
804 J. C. Black MD	Box 777 Parma Ida	12 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 19, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 23, 1969	Mrs. Martin Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 5 1970

MAY 2 7 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5669
Local Reg. No. 6
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 140 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilder
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilder
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	Henry	Hoots	Dec. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	March 8, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
60		Wright County, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Hoots	Missouri	Kizaria Allen	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-60-6222	Clonia Hoots	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Inspection only *, to* _____ *, 19____, that I last saw the deceased alive on* _____ *, 19____, and that death occurred at* 7 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wenck 583 4	M. D. Coroner	Nampa, Idaho	12-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 19, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
January 5, 1970	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5670
Local Reg. No. 604
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (In this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor Nursing Home 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kuna
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Charley b. (Middle) A. c. (Last) Robbins

4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Jan. 10, 1883

9. AGE (In years last birthday) 86
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY retired

11. BIRTHPLACE (State or foreign country) Gentry, Arkansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wilson Robbins
BIRTHPLACE Tenn.

14. MOTHER'S MAIDEN NAME Jane Holland
BIRTHPLACE Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-60-6941T

17. INFORMANT'S OWN SIGNATURE Mrs John D. Keeffer
ADDRESS Mtn Home

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardio-vascular- renal Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-3-64, 19__, to 12-17-69, 19__, that I last saw the deceased alive on 12-10-69, 19__, and that death occurred at 10:00A m., from the causes and on the date stated above.

23a. SIGNATURE Henry C. Wesche 560 (Degree or title) M. D.

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED 12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE 12-20-69

24c. NAME OF CEMETERY OR CREMATORY Kuna Cemetery

24d. LOCATION (City, town, or county) Kuna, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 29, 1969

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Jack D. Green

LICENSE NO. 528

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 1 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5671
Local Reg. No. 601
Reg. Dist. No. 360

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon (141)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakeley Nursing Home (77)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon (141)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1624 Arthur

3. NAME OF DECEASED (Type or Print)
a. (First): Horace
b. (Middle): D.
c. (Last): Wilford

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 17, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Jan. 8, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR — Months: 11 Days: 9
IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (04)

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Republic, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard Wilford
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Grace Draper
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-40-5942

17. INFORMANT'S OWN SIGNATURE: Mabel L. Tinder
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral thrombosis — 5 months
DUE TO (c) Arteriosclerotic Cardio-vasc disease — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

4/24

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3 Dec, 1963, *to* 17 Dec, 1969, *that I last saw the deceased alive on* 16 Dec, 1969, *and that death occurred at* 2:50 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. H. Simpson M.D. (473)

23b. ADDRESS: Caldwell

23c. DATE SIGNED: 22 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-22-1969

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Dec. 26, 1969

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Leonard C. Flahiff

LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 1 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5672
Local Reg. No. 608
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakeley Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Caldwell
d. STREET ADDRESS (If rural, give location): Route # 5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Frederick	C.	Bohlson	December 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	1-15-1880	89	11	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.S. Reclamation 08	Retired	Oshkosh, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jake Bohlson	Unknown	Ellen Oltman	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-0521A	James W Bowlby	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovasc. disease — 20 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
none		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan, 1964, *to* 18 Dec, 1969, *that I last saw the deceased alive on* 18 Dec, 1969, *and that death occurred at* 9 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. D. Simpson 473	M.D.	Caldwell	24 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	12-23-1969	Fir Lawn Cemetery	Hillsboro, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Mrs. Martine Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 16 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5673
Local Reg. No. 3
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma
d. STREET ADDRESS (If rural, give location): Rt. # 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Washington	G.	Sparks	Dec. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Dec. 23, 1885	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
60		Union County, Georgia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James F. Sparks	Georgia	Lavina Freeman	Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-26-1358A	X E Edwards Sparks	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

188X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bilateral hydronephrosis
DUE TO (c) Transitional cell carcinoma of the bladder - months

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bilateral bronchopneumonia, arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-26-69, 19__, *to* 12-18-69, 19__, *that I last saw the deceased alive on* 12-18-69, 19__, *and that death occurred at* 10:25A. *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Reed M.D	379	232 E. Elm, Caldwell Idaho	12/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 18	Dec. 22, 1969	Roswell Cemetery	Roswell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
January 5, 1970	Mrs. Martin Walmsley	Kenneth E. Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 5674
Local Reg. No. 602
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 — DEC 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY IN (this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. -Mercy Hospital 450

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa,
d. STREET ADDRESS (If rural, give location): Rt. # 3,

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HENRY	CLAY	CRAIG	Dec. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Oct. 23, 1915	54	1 / 26	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter "	Building	Sutherland, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John C. Craig	Missouri	Rose J. Dickey	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes / W.W.2 4	700-01-7259	X John C Craig	Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coroner Occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Inspection Only, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at About 1 P. M. from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wernie 583 M. D. 4 (Degree or title) Coroner	Nampa. Idaho	12-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/22/69	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Mrs. Martin Walmsley	Richard W. Mesenbrink	E-488

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5675
Local Reg. No. 603
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Canyon 140 DEC 30 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Route #4 Nampa LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Route #4 Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route #4, Nampa	d. STREET ADDRESS (If rural, give location) Route #4

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mabel	Etta	Wilson	Dec.	19,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Never Married	July 5, 1879	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
home maker or at home	at home	Selma, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
F.M. Wilson	Ohio	Laura Warner	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-54-0958	Family Records by: Tony J. Krouth	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CORONARY Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4109

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CEREBRAL HEMORRHAGE
DUE TO (c) Arteria Sclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
[illegible] 1965 m.		

22. *I hereby certify that I attended the deceased from* 8-30- 1965 *to* 12-19-69, 19____, *that I last saw the deceased alive on* 12-19-, 1969, *and that death occurred at* 11 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Samuel A. Swayne M.D. 517	Nampa, Idaho.	12-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation 3	Dec. 22, 1969	Mountain View Crematory	Ada County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Mrs. Martin's Walmsley	Richard W. Meservey	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5676
Local Reg. No. 18
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Canyon 141

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Canyon 141

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

d. STREET ADDRESS (If rural, give location): 1307 Belmont St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Myrtle	Edna	Campbell	Dec. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Oct. 9, 1898	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CD		Raymond, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Snoden Allen White	Missouri	Edith Markle	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-24-7142 A	Gilbert Campbell	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Multiple pulmonary emboli — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Atherosclerosis of right lung, congestive failure, cerebral degeneration

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes XX No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-6-68, 19____, *to* 12-20-69, 19____, *that I last saw the deceased alive on* 12-20-69, 19____, *and that death occurred at* 10:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Neal 379 M.D.	222 East Elm, Caldwell, Idaho	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec. 24, 1969	Owyhee Cemetery	Malheur County

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 12, 1970	Mrs. Martha Walmsley	Kenneth E Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5677
Local Reg. No. 4
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell — LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Dr. Joseph	b. (Middle) H.	c. (Last) Gasper	4. DATE OF DEATH (Month) (Day) (Year) Dec. 20, 1969		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 27, 1886	9. AGE (In years last birthday) 83	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lyons, Iowa	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown	BIRTHPLACE Unknown	14. MOTHER'S MAIDEN NAME Unknown	BIRTHPLACE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-60-0117T	17. INFORMANT'S OWN SIGNATURE Mrs Lydia Jurrils	ADDRESS		

887X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Fracture R femur — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Broncho pneumonia — 2 wks

19a. DATE OF OPERATION Dec 5 1969	19b. MAJOR FINDINGS OF OPERATION Fracture R femur	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT XXX SUICIDE HOMICIDE 1 (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Nursing Home 13	21c. (CITY, TOWN, OR TOWNSHIP) Homedale 13370 (COUNTY) Owyhee (STATE) Idaho	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) December 10, 1969 6a m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Fell in nursing home injuring R hip & face	

22. *I hereby certify that I attended the deceased from* Dec 4, 1969, *to* Dec 20, 1969, *that I last saw the deceased alive on* Dec 20, 1969 *and that death occurred at* 6 p m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 570 (Degree or title) MD	23b. ADDRESS Caldwell Ida	23c. DATE SIGNED 12-24-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 3	24b. DATE Dec.24,1969	24c. NAME OF CEMETERY OR CREMATORY Mt. View Crematory	24d. LOCATION (City, town, or county) (State) Boise, Idaho
DATE REC'D BY LOCAL REG. January 5, 1970	REGISTRAR'S SIGNATURE Mrs. Martin Walmsley	25. EMBALMER Kenneth E Spence	LICENSE NO. E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5678
Local Reg. No. 614
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 31 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place) 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, 83651
d. STREET ADDRESS (If rural, give location) 411 15th Ave. So.

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) I. c. (Last) STARLIN

4. DATE OF DEATH (Month) (Day) (Year) December 20, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 11, 1937
9. AGE (In years last birthday) 32 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Hamberg, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leo White BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Laura Vermon BIRTHPLACE Hamberg, Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-40-5384
17. INFORMANT'S OWN SIGNATURE X De Wayne Starlin ADDRESS

18. CAUSE OF DEATH 6200
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH —

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Heart Failure — 4 hrs
DUE TO (c) Postoperative State — 10 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Psychosis — 4 days.

19a. DATE OF OPERATION Dec. 9 1969
19b. MAJOR FINDINGS OF OPERATION ① Uterine Prolapse (Chronic Cervicitis) ② Panniculus
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12.3, 1969, *to* 12-20, 1969, *that I last saw the deceased alive on* 12-19, 1969, *and that death occurred at* 3:15a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 876 [signature] (Degree or title)
23b. ADDRESS 222 E. LOGAN Caldwell, Ida
23c. DATE SIGNED 12-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12=23=69
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. Dec. 30, 1969
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Glen S. Siren
LICENSE NO. E-498

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5679
Local Reg. No. 5
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, Box 283, Wilder (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (140)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Box 283

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Fred	Thomas	Hodge	Dec. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Nov. 17, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer (47)		Mountain Home, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George F. Hodge	Missouri	Dora Nall	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	495-01-7385	Delbert T. Hodge RT #1 Weiser	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Inspection only, 19____, to _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* Found dead at 7 A.M. *on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wesche 583	M. D. Coroner (4)	Nampa, Idaho	12-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 24, 1969	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
January 5, 1970	Mrs. Martina Walmsley	Rodney L. Dakan	E-505

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 1 4 1970

JUL 2 9 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 13 1970 Bureau of Vital Statistics

State File No. 5680
Local Reg. No. 16
Reg. Dist. No. 360
BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 15 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 151

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1815 2nd St. North

3. NAME OF DECEASED (Type or Print) a. (First) Jesus b. (Middle) (NMN) c. (Last) Lopez
4. DATE OF DEATH (Month) (Day) (Year) Dec. 22, 1969
5. SEX Male
6. COLOR OR RACE Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown
8. DATE OF BIRTH May 5, 1899
9. AGE (In years last birthday) 70
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Labor
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Mexico
12. CITIZEN OF WHAT COUNTRY? Mexico
13. FATHER'S NAME No Record
BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME No Record
BIRTHPLACE No Record
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 522 05 5637
17. INFORMANT'S OWN SIGNATURE M B Shepherd
ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Ventricular Standstill	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypokalemia	1 wk
DUE TO (c)	Uremia	6 wks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	ASHD & Congestive Failure	6 wks

4123

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5 Dec 19 69, to 22 Dec 19 69, that I last saw the deceased alive on 22 Dec 19 69 and that death occurred at 12:00 P m., from the causes and on the date stated above.

23a. SIGNATURE Grayson Olsen MD (Degree or title)
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 26 Jan 70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-30-69
24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. Jan. 9, 1970
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Glen L. Sisson
LICENSE NO. 498
FIRM NAME Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 1 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5681
Local Reg. No. 8
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY Canyon JAN 7 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (In this place) 9 years

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, 83651
d. STREET ADDRESS (If rural, give location) 1606 Rail Road

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
W.	Ray	Wolfe	December 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	January 24, 1893	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Agriculture	Western, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Norris Wolfe	No Record	Martha Witt	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-62-3227	X Dorothy Wiedenfeld	Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia	1wk
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Fractured Hip	1week
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Epilepsy	10yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1962 *to* Dec 22 1965 *that I last saw the deceased alive on* Dec 14 1969 *and that death occurred at* 4:35p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Nampa Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 26, 1969	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
January 6, 1970	Mrs. Martina Walmsley	R. A. Shepherd	E-473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH–63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5682
Local Reg. No. 1
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY (42) Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon (42)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 811-7th. Ave. South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	H.	Fedler	December 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	December 15, 1903	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Carman (10)	P.F.E.	Ritter, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Fedler	Germany	Catherine Heine Schroeder	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	700-09-3163	Elden Fedler	Beaverton, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 404X Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1 Dec 69 to 24 Dec 69, that I last saw the deceased alive on 24 Dec 69, and that death occurred at 6:00A m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Wanzum MD 327	Nampa Idaho	31 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Dec. 29, 1969	Hillcrest Cemetery	Canyon County	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	26. EMBALMER	LICENSE NO.
Jan. 2, 1970	Irene M. Kuntz RN	Richard W. Mesenbrink	E-487

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5683
Local Reg. No. 23
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon (47)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Curtis Park ccc

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Canyon (47)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 411 Chicago St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joseph	L.	Fulton	December 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 26, 1947	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Draftsman 2/		Monterey, California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jess L. Fulton, Sr.	Texas	Mae Garner	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Viet Nam 7	553-58-3389	Ray Fulton	

8769

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Drowning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Alcoholic Intoxication
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes XX No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Curtis Park. Caldwell 13141		Canyon	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
Dec 24 1969 ? m.	NOT WHILE AT WORK x	Car ran over cliff and turned over in river

22. *I hereby certify that I attended the deceased from* Inspection and autopsy, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wesen 583 M.D. Coroner	Nampa, Idaho	1-9-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation 3	Dec. 31, 1969	Mt. View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 12, 1970	Mrs. Martina Walmsley	James R. Dakan FIRM NAME: Dakan Chapel, Caldwell, Idaho	E-485

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 26 1970

FEB 3 1970

FEB 25 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5684
Local Reg. No. 33
Reg. Dist. No. 360

Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 20 1970
Bureau of Vital

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 26 Custer Dr.

3. NAME OF DECEASED (Type or Print)
a. (First): RONALD
b. (Middle): EDWARD
c. (Last): MacKenzie

4. DATE OF DEATH (Month) 12 (Day) 24 (Year) 69

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 4, 1930
9. AGE (In years last birthday): 39 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction
10b. KIND OF BUSINESS OR INDUSTRY: Feller Trucking
11. BIRTHPLACE (State or foreign country): Rupert, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: A. D. MacKenzie — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Marie M. Isenberg — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Two 4
16. SOCIAL SECURITY NO.: 518-34-2839
17. INFORMANT'S OWN SIGNATURE: Velora MacKenzie — ADDRESS:

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs., 40 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/24/69, 19__, *to* 24 December, 1969, *that I last saw the deceased alive on* 24 December, 1969, *and that death occurred at* 6:45p *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 250 (Degree or title): M.D.
23b. ADDRESS: 222 East Elm, Caldwell, Idaho
23c. DATE SIGNED: 1/14/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/29/69
24c. NAME OF CEMETERY OR CREMATORY: Margaret
24d. LOCATION (City, town, or county) (State): Cascade, Idaho

DATE REC'D BY LOCAL REG.: Jan. 16, 1970
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff — LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 21 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 15 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

BIRTH NO. 69-9180

RECEIVED JAN 7 1970 Bureau of Vital Statistics

State File No. 5685
Local Reg. No. 7
Reg. Dist. No. 360

1. PLACE OF DEATH a. COUNTY Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 05	d. STREET ADDRESS (If rural, give location) 319-So. 11th

3. NAME OF DECEASED (Type or Print)	a. (First) Carmen	b. (Middle)	c. (Last) Pacheco	4. DATE OF DEATH (Month) (Day) (Year) Dec. 24. 1969
5. SEX Female	6. COLOR OR RACE Mexican	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH Sept. 21, 1969	9. AGE (In years last birthday) IF UNDER 1 YR. Months 3 Days 3 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 02	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Caldwell, Idaho	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Fredricos Pacheco	BIRTHPLACE Texas		14. MOTHER'S MAIDEN NAME Sally Serna	BIRTHPLACE New Mexico
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT'S OWN SIGNATURE X Federico Pacheco	ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

3209

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardio Vascular Collapse	—
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Bacterial Septicemia	4HR
DUE TO (c)	Bacterial Meningitis	12HR.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 12-23, 1969, *to* 12-24, 1969, *that I last saw the deceased alive on* 12-24, 1969, *and that death occurred at* 12:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE A.R. Neumann Dec 876 MD (Degree or title)	23b. ADDRESS 222 E. Logan - Caldwell	23c. DATE SIGNED 12-31-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 29, 1969	24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery	24d. LOCATION (City, town, or county) (State) Caldwell, Idaho
DATE REC'D BY LOCAL REG. January 6, 1970	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Kenneth E. Spencer	LICENSE NO. E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5686
Local Reg. No. 26
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JAN 14 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital (85)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) So. 10th & Karcher

3. NAME OF DECEASED (Type or Print) a. (First) Merrill b. (Middle) E. c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 28, 1905

9. AGE (In years last birthday) 64

IF UNDER 1 YR. Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CD

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Battle Creek, Michigan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Sam Smith
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Jennie Eaton
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 482-40-0961

17. INFORMANT'S OWN SIGNATURE Mrs. Elsie F. Smith
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: One hour or less

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe coronary artery sclerosis — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus + insulin shock — 9yrs + 45 months respectively

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 2, 1963, to Dec 24, 1969, that I last saw the deceased alive on 24 December, 1969, and that death occurred at 7:35 A.M. from the causes and on the date stated above.

23a. SIGNATURE Irving N. Kellogg MD (Degree or title)

23b. ADDRESS Caldwell, Idaho

23c. DATE SIGNED 12 Jan. 70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 26, 1969

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Garden

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Jan. 13, 1970

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Rodney W. Dakan

LICENSE NO. E-508

FIRM NAME: Dakan Funeral Chapel, Caldwell

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5687
Local Reg. No. 11
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 8 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma
d. STREET ADDRESS (If rural, give location) Rt. # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Golda	E.	Siebenberg	Dec. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Dec. 15, 1898	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CO
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cottonwood, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Perry N. Powell	Virginia	Clara Bell Orr	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-26-9734B
17. INFORMANT'S OWN SIGNATURE Walter Siebenberg ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

159X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cancer upper G I tract — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Klebsiella pneumonia
DUE TO (c) Cardiac failure

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.
23b. ADDRESS Box 177 Parma
23c. DATE SIGNED 3 Jan 70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 29, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7, 1970	Mrs. Martina Walmsley	Kenneth E. Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 25 1999

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED JAN 20 1970 Bureau of Vital Statistics

State File No. 5688
Local Reg. No. 31
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospitl 25,

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (4)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1513 Fairview

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Floyd		Williamson	Dec. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Nov. 19, 1904	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
co		Paoli, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Williamson		Jennie Carlyle	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-0766A	Floyd Williamson	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3959

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute stasis — INTERVAL BETWEEN ONSET AND DEATH: many yrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) and acute myocardial injuries — 1 day
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* December 8, 19 69, *to* December 25, 19 69, *that I last saw the deceased alive on* December 25, 19 69, *and that death occurred at* 1:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. D.	222 E. Elm, Caldwell, Idaho	1/14/70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 30, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 16, 1970	Mrs. Martina Walmsley	Kenneth E Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 2 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5689
Local Reg. No. 36
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 20 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkview Manor Nursing Home 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 711½ Fillmore St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lillie		Mayfield	December 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Sept. 17, 1882	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
or		Salubria, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Ingman	Unknown	Unknwon	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-03-1888	E. F. Mayfield	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarct — Sudden
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ASHD — 10 yrs
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec 26 1962 *to* Dec 26 1969 *that I last saw the deceased alive on* Dec 26 1969 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.		Jan 19 1970

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 31, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 19, 1970	Mrs. Martina Walmsley	James R. Dakan	E-485

FIRM NAME: Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5690
Local Reg. No. 13
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 9 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon (14)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon (14)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1109 Blaine St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	A.	Billings	Dec. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Aug. 16, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Harlan, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William E. Billings	Unknown	Ora J. Trotter	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-16-4641A	x Merlin Billings	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	B & H	Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* Dec. 28, 1969, *and that death occurred at* 5:52p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur S. Daly M.D.	Caldwell, Idaho	1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 31, 1969	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
January 8, 1970	Mrs. Martina Walmsley	Rodney A. Dakan	E-508

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 4 19

FEB 20 1970

JAN 20 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5691
Local Reg. No. 12
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JAN 8 1970
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Canyon 141	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Oregon 38 b. COUNTY: Marion 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salem
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051	d. STREET ADDRESS (If rural, give location): Park Avenue North

3. NAME OF DECEASED (Type or Print)	a. (First): Arley	b. (Middle): M.	c. (Last): Dencer	4. DATE OF DEATH (Month) (Day) (Year): Dec. 28, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Jan. 30, 1885	9. AGE (In years last birthday): 84 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Vale, Oregon	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Robert Linebarger	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Ermina Johnson	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 543-07-6411	17. INFORMANT'S OWN SIGNATURE: Hazel Sigram	ADDRESS:	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): previous myocardial infarction

DUE TO (c): cancer multiple lymphomas

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: J. C. Stark 804 (Degree or title) MD	23b. ADDRESS: Box 277 Pavia	23c. DATE SIGNED: 3 Jan 70

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3	24b. DATE: Dec. 31, 1969	24c. NAME OF CEMETERY OR CREMATORY: Salem, Oregon	24d. LOCATION (City, town, or county) (State): Salem, Oregon

DATE REC'D BY LOCAL REG.: Jan. 7, 1970	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: Kenneth E. Spence	LICENSE NO.: E-395

FIRM NAME: Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 8 1970 Bureau of Vital Statistics

State File No. 5692
Local Reg. No. 9
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 19 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa
d. STREET ADDRESS (If rural, give location) Route 5

3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) A. c. (Last) Leuthaeuser

4. DATE OF DEATH (Month) (Day) (Year) Dec. 28, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 11, 1909
9. AGE (In years last birthday) 60 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian 06
10b. KIND OF BUSINESS OR INDUSTRY J.C. Penneys
11. BIRTHPLACE (State or foreign country) St. Libory, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Albert Leuthaeuser BIRTHPLACE Neb.
14. MOTHER'S MAIDEN NAME Mary Koch BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 506 20 4620
17. INFORMANT'S OWN SIGNATURE Mrs Walter Leuthaeuser ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 19 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) with ventricular rupture

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/9/ *, 19* 69 *to* 12/28/ *, 19* 69 *, that I last saw the deceased alive on* 12/28/ *, 19* 69 *and that death occurred at* 10:40A *, from the causes and on the date stated above.*

23a. SIGNATURE Richard C. Twyer (Degree or title) MD
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 12-29-69
24c. NAME OF CEMETERY OR CREMATORY Westlawn Memorial
24d. LOCATION (City, town, or county) (State) Grand Island, Neb.

DATE REC'D BY LOCAL REG. January 7, 1970
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER M. B. Shepherd
LICENSE NO. 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 9 1970
JAN 20 1970
FEB 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5693
Local Reg. No. 10
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 8 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MIDLAND MANOR 30

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE IDAHO
b. COUNTY ADA 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) KUNA
d. STREET ADDRESS (If rural, give location) ROUTE # 2

c. LENGTH OF STAY (In this city)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOSEPHINE	B.	PULLEN	DECEMBER 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W	WIDOWED	APRIL 20, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	-----	EPHRIAM UTAH	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
NO RECORD	---	MARY ONESEN	NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518 40 1002D	Ellwood C. Carleson	COMPTON, CALIF.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

450X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec 60, *to* Dec 29, 19 69, *that I last saw the deceased alive on* 31 Dec, 19 69, *and that death occurred at* 2:35 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 326 MD	Nampa Idaho	1/4/70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 3	JAN. 2, 1970	SHELLEY CEMETERY	SHELLEY IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7, 1970	Mrs. Martina Walmsley	[signature] FIRM NAME: CALSIP FUNERAL CHAPEL	E-496

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 9 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5694
Local Reg. No. 2
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa	c. LENGTH OF STAY (In this place)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050	d. STREET ADDRESS (If rural, give location) 311 West Sheridan Street

3. NAME OF DECEASED (Type or Print)	a. (First) Harry	b. (Middle) Allen	c. (Last) Severn	4. DATE OF DEATH (Month) (Day) (Year) December 29, 1969.
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 7, 1883	9. AGE (In years last birthday) 86 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor 10	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Montpelier	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM SEVERN	BIRTHPLACE England	14. MOTHER'S MAIDEN NAME Annie Kelly	BIRTHPLACE England	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 712-05-1515	17. INFORMANT'S OWN SIGNATURE Russell Severn	ADDRESS Nampa, Idaho.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

968X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Hemorrhage	5 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Ruptured abdominal aneurysm	3-5 days
	Pneumonia ~~3-5 d~~	3-5 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes XX No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 3 Homicide	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Nursing Home 13	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13142	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) December 24 1969 m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Beaten by a fellow patient	

22. *I hereby certify that I attended the deceased from* 2/17/ *, 19* 69 *to* 12/29/ *, 19* 69 *, that I last saw the deceased alive on* 12/29/ *, 19*69 *, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Robert E Hay 217 M.D. (Degree or title)	23b. ADDRESS 619 So. Canyon, Nampa, Idaho	23c. DATE SIGNED 1/2/70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE Jan. 3, 1970	24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery	24d. LOCATION (City, town, or county) (State) Montpelier, Idaho

DATE REC'D BY LOCAL REG. January 5, 1970	REGISTRAR'S SIGNATURE Mrs. Martina Walmsley	25. EMBALMER Don W. Singiani	LICENSE NO. E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 7 1970
MAY 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5695
Local Reg. No. 19
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Canyon 142	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kuna
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050	d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print)	a. (First) Leonard	b. (Middle) M.	c. (Last) Petersen	4. DATE OF DEATH (Month) (Day) (Year) 12 - 30 - 69
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 9-23-1909	9. AGE (In years last birthday) 60 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 04	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (State or foreign country) Lindsey, Nebraska	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter F. Petersen	BIRTHPLACE Denmark	14. MOTHER'S MAIDEN NAME Sena Johnson	BIRTHPLACE Nebraska	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 543-16-7922	17. INFORMANT'S OWN SIGNATURE Mrs Leonard Petersen	ADDRESS Kuna	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of the lung

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1969, *to* Dec 30, 1969, *that I last saw the deceased alive on* Dec 28, 1969, *and that death occurred at* 4 2 *m., from the causes and on the date stated above.*

23a. SIGNATURE Marvin E Blough (Degree or title) 130	23b. ADDRESS Nampa Idaho	23c. DATE SIGNED 1-5-70	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 1-3-70	24c. NAME OF CEMETERY OR CREMATORY Kuna Cemetery	24d. LOCATION (City, town, or county) (State) Kuna, Idaho
DATE REC'D BY LOCAL REG. Jan. 12, 1970	REGISTRAR'S SIGNATURE Mrs. Martin's Walmsley	25. EMBALMER Jack H. Green	LICENSE NO. E-528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5696
Local Reg. No. 37
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
JAN 21 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 112-13 AVENUE NORTH

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	Jenkinson	Price	DECEMBER 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	Married	Jan. 21, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Caretaker-Cemetery	Cemetery	Logan, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John E. Price	England	Laura A. Jenkinson	Rhode Island

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-03-1219	Mrs. William J. Price	Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction	1 hour
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	arteriosclerotic heart disease	20 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1965, 19__, to Dec 30, 1969, that I last saw the deceased alive on Dec 29, 1969, and that death occurred at 8:38A. m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold Brown	M.D.	619 So Canyon Nampa	1/20/70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jan. 2, 1970	Kohlerlawn Cemetery	Nampa Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 20, 1970	Mrs. Martina Walmsley	Marvin R. Kukkola	E-515

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 11 1970

JUL 13 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5697
Local Reg. No. 14
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 9 1970 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 321 W. Hazel, Rt. # 2
d. STREET ADDRESS (If rural, give location): Caldwell

3. NAME OF DECEASED (Type or Print): a. (First) Lola b. (Middle) E. c. (Last) Stearns

4. DATE OF DEATH (Month) (Day) (Year): Dec. 31, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 19, 1892

9. AGE (In years last birthday): 77
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oakland, California

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George F. Emery
BIRTHPLACE: Maine

14. MOTHER'S MAIDEN NAME: Ella M. Mixon
BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-42-6104B

17. INFORMANT'S OWN SIGNATURE: L. E. Stearns
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Coronary occlusion

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis — 3 Days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes, mellitus; Generalized arteriosclerosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec 28, 1969, *to* Dec 31-69, 19____, *that I last saw the deceased alive on* Dec 30, 1969, *and that death occurred at* 6 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.

23b. ADDRESS: Caldwell Idaho

23c. DATE SIGNED: 1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jan. 5, 1970

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: January 8, 1970

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: James R. Dakan

LICENSE NO.: E-485

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 19 1970
MAR 31 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 15 1970
OCT 30 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5698
Local Reg. No. 12
Reg. Dist. No. 520-521

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Caribou 150 DEC 23 1969
b. CITY OR TOWN Soda Springs
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 140 West 3rd North 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Caribou 150
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Soda Springs
d. STREET ADDRESS (If rural, give location) 140 West 3rd North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Inez	Maude Sibbett	Skinner Muir	Dec. 10, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married	May 8, 1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Gray, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James L. Sibbett	Morgan, Utah	Genievive Hacking	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-38-3714T	John Muir	Soda Springs, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-10, 1968, *to* 11-14, 1969, *that I last saw the deceased alive on* 12/14, 1969, *and that death occurred at* 3:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Soda Springs Ida	12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/13/69	Fairview Cemetery	Soda Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-19-69	Norene Bunn	[signature]	E370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Allen Funeral Home

DUTIES: DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5699
Local Reg. No. 93
Reg. Dist. No. Sa-S-21

BIRTH NO.

RECEIVED DEC 18 1969 Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Caribou (150)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou Memorial Hospital (069)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou (150)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Conda
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) b. (Middle) c. (Last): Edythe Georgia Wren Junes

4. DATE OF DEATH (Month) (Day) (Year): Dec. 12, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec. 17, 1906

9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): St. Paul, Minnesota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Wren
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Mary Smolik
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE: Albert O Junes
ADDRESS: Conda, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Colon (1538)
INTERVAL BETWEEN ONSET AND DEATH: Appx 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 9, 1969, *to* Dec 12, 1969, *that I last saw the deceased alive on* Dec 11, 1969, *and that death occurred at* 7:36 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ronnie Izgut (535) (Degree or title): MD
23b. ADDRESS: Soda Springs Idaho
23c. DATE SIGNED: 12/16/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/15/69
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: 12-16-69
REGISTRAR'S SIGNATURE: Norene Bunn
25. EMBALMER: Theodore L Allen
LICENSE NO.: E370
FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 21 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

State File No. 5700
Local Reg. No. 14
Reg. Dist. No. 520-521

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 040
a. STATE Idaho
b. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 230 South 9th

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Hyrum c. (Last) Skinner

4. DATE OF DEATH (Month) (Day) (Year) Dec. 16, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 19, 1907
9. AGE (In years last birthday) 62 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 10
10b. KIND OF BUSINESS OR INDUSTRY U.P.R.R.
11. BIRTHPLACE (State or foreign country) Naunan Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David P. H. Skinner BIRTHPLACE Naunan Ida
14. MOTHER'S MAIDEN NAME Elizabeth A. Munro BIRTHPLACE Cartiniff Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 712-07-7106
17. INFORMANT'S OWN SIGNATURE Clifford Skinner ADDRESS Dingle Ida

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 5 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart disease 10 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* 16 Dec, 1969, *that I last saw the deceased alive on* 16 Dec, 1969 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 458 J. W. Schoppe (Degree or Title) 60 MD
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Dec. 19, 1969
24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery
24d. LOCATION (City, town, or county) Montpelier (State) Idaho

DATE REC'D BY LOCAL REG. 1-9-70
REGISTRAR'S SIGNATURE Norine Bunn
25. EMBALMER Nile Matthews
LICENSE NO. E359

FIRM NAME Matthews Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5701
Local Reg. No. 12
Reg. Dist. No. 520-521

BIRTH NO.

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH (150)
a. COUNTY: Caribou
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grace
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GOO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou (50)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grace
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) b. (Middle) c. (Last): Michael Alan Shaw

4. DATE OF DEATH (Month) (Day) (Year): Dec. 18, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: Nov. 28, 1965

9. AGE (In years last birthday): 4
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant (02)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Soda Springs, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Byron K. Shaw
BIRTHPLACE: Evanston, Wyo.

14. MOTHER'S MAIDEN NAME: Marianne Marshall
BIRTHPLACE: Evanston, Wyo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Byron Shaw
ADDRESS: Grace, Idaho

18. CAUSE OF DEATH (9250)
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Electrocution
INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify): 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home (01)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Grace (13150) Caribou Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 18, 1969 - 8:09 PM

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: He poked a nail into a 110 volt wall plug

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:09 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: E E Herron MD (226) (Degree or title)

23b. ADDRESS: Box 343 Grace, Idaho 83241

23c. DATE SIGNED: 12/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial (3)

24b. DATE: 12/22/69

24c. NAME OF CEMETERY OR CREMATORY: Evanston Cemetery

24d. LOCATION (City, town, or county) (State): Evanston, Wyoming

DATE REC'D BY LOCAL REG.: 12-30-69

REGISTRAR'S SIGNATURE: Dorene Bunn

25. EMBALMER: Theodore A Allen

LICENSE NO.: E370

FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5702
Local Reg. No. 72
Reg. Dist. No. 520-521

BIRTH NO.

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Caribou
b. CITY OR TOWN: Soda Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 461 So. Second East

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
d. STREET ADDRESS (If rural, give location): 461 So. Second East

3. NAME OF DECEASED (Type or Print): a. (First) Ernest b. (Middle) Reginol c. (Last) Cooley

4. DATE OF DEATH (Month) (Day) (Year): Dec. 19, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Jan. 1, 1907

9. AGE (In years last birthday): 62
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer-retired

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Rupert, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Leonard Cooley — BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Lois Albiston — BIRTHPLACE: Richmond, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.: 519-07-4212

17. INFORMANT'S OWN SIGNATURE: Mrs Ernest Cooley — ADDRESS: Soda Springs, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on Dec. 19, 1969, and that death occurred at _____ a.m., from the causes and on the date stated above.*

23a. SIGNATURE: Leonard S Allen 583 — (Degree or title): Coroner
23b. ADDRESS: Soda Springs, Ida.
23c. DATE SIGNED: 12/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/23/69
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: 12-26-69
REGISTRAR'S SIGNATURE: Morene Bunn
25. EMBALMER: Leonard S Allen
LICENSE NO.: E370

FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 8 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5703
Local Reg. No. 17
Reg. Dist. No. 520-521

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Caribou 150 JAN 2 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Delbert b. (Middle) Daniel c. (Last) Bock

4. DATE OF DEATH (Month) (Day) (Year): Dec. 26, 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: Nov. 11, 1910

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Sidney, Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George P. Bock
BIRTHPLACE: Sheridan, Montana

14. MOTHER'S MAIDEN NAME: Minnie Borgstrom
BIRTHPLACE: BrighamCity, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.: 529-05-6090

17. INFORMANT'S OWN SIGNATURE: Glen A. Bock
ADDRESS: Brigham City, Ut.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7854

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac failure
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Theodore A Allen (Degree or title): Coroner
23b. ADDRESS: Soda Springs, Idaho
23c. DATE SIGNED: 12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/30/69
24c. NAME OF CEMETERY OR CREMATORY: Bancroft Cemetery
24d. LOCATION (City, town, or county) (State): Bancroft, Idaho

25. EMBALMER: Theodore A Allen
LICENSE NO.: E370

DATE REC'D BY LOCAL REG.: 12-31-69
REGISTRAR'S SIGNATURE: Norene Bunn

FIRM NAME: Allen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5704
Local Reg. No. 2057
Reg. Dist. No. 470

Certificate of Death

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia (161)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home Air Force Base
d. STREET ADDRESS (If rural, give location): 4531-A Palm St.

3. NAME OF DECEASED (Type or Print)
a. (First): MRS. DORIS
b. (Middle): IMOGENE
c. (Last): JOHNSON

4. DATE OF DEATH (Month) (Day) (Year): Dec. 4, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 21, 1932
9. AGE (In years last birthday): 37 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse 13
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Hartford, Arkansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter H. Watson — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Gertrude — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Military Health Records, M.H.AFB, Idaho — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8199 Skull fract. Cerebral Concussion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES — Traumatic Chest. Pulmonary Contusion
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): ~~[illegible]~~ 13160
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 4, 1969 5:15PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 4, 1969, *to* Dec 4, 1969, *that I last saw the deceased alive on* Dec 4, 1969, *and that death occurred at* 8:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 276 ~~Coroner~~ M.D.
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 12-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/6/69
24c. NAME OF CEMETERY OR CREMATORY: Malvern, Arkansas
24d. LOCATION (City, town, or county) (State): Malvern, Arkansas

DATE REC'D BY LOCAL REG.: Dec. 24, 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: H. Neal Humphreys
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 20 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 21 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 11 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5705
Local Reg. No. 2058
Reg. Dist. No. 470

RECEIVED
DEC 29 1969
Bureau of Vital Stat.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Cassia County
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ✓I-80 Cassia County 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home Air Force Base
d. STREET ADDRESS (If rural, give location): 4531-A Palm St.

3. NAME OF DECEASED (Type or Print)
a. (First): RICHARD
b. (Middle): W.
c. (Last): JOHNSON

4. DATE OF DEATH (Month) (Day) (Year): Dec. 4, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 14, 1932
9. AGE (In years last birthday): 37 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): T/Sgt. Air Force 05
10b. KIND OF BUSINESS OR INDUSTRY: Military Service
11. BIRTHPLACE (State or foreign country): Hudson, Michigan
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lawrende W. Johnson — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Bernice L. Fellabaum — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 9/20/52-present
16. SOCIAL SECURITY NO.: 375-32-7731
17. INFORMANT'S OWN SIGNATURE: Military Service Records — ADDRESS: MHAFB, Idaho

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed left side of chest, fractured skull, fractured jaw.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): ✓Rural 13160 Cassia Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 4, 1969 6:15 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: ✓Automobile accident

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 6:15 p.m., from the causes and on the date stated above.*

23a. SIGNATURE: C. Bruce Young 583 4 (Degree or title): Coroner
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: ✓12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/6/69
24c. NAME OF CEMETERY OR CREMATORY: Malvern, Arkansas
24d. LOCATION (City, town, or county) (State): Malvern, Arkansas

DATE REC'D BY LOCAL REG.: Dec. 24 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: H. Weil Humphrys
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 16 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 21 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5706
Local Reg. No. 2059
Reg. Dist. No. 470

RECEIVED DEC 29 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Cassia County
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): T-80 Cassia County

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home Air Force Base
d. STREET ADDRESS (If rural, give location): 4531-A Palm St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WESLEY	S.	JOHNSON	Dec. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	March 20, 1967	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child 02		Trier, Germany	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard W. Johnson	Michigan	Doris I. Watson	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Military Health Records, M.A.F.B.	Idaho

MEDICAL CERTIFICATION

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fracture — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 06	Rural 13/60 Cassia Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Sec. 4, 1969 8:15 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Automobile, accident

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	Burley, Idaho	12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12/16/69	Malvern, Arkansas	Malvern, Arkansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 24 1969	Ruth N. Pierson	[signature]	E-302

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 20 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 21 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

X The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5707
Local Reg. No. 2052
Reg. Dist. No. 470

Certificate of Death

RECEIVED
DEC 15 1969
Bureau of V.

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) 3½ Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Walter
b. (Middle)
c. (Last) Lewis

4. DATE OF DEATH (Month) Dec. (Day) 6, (Year) 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH May 22, 1906
9. AGE (In years last birthday) 63 — IF UNDER 1 YEAR Months 6 Days 8 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Itasca, Texas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) — — —
16. SOCIAL SECURITY NO. 700-18-2300
17. INFORMANT'S OWN SIGNATURE Bettie Wilson 1970 Garfield Eugene, Oregon — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1989

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic sq. cell Ca of hypoxhorg — INTERVAL BETWEEN ONSET AND DEATH 5 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* aug, 1968, *to* dec, 1969, *that I last saw the deceased alive on* Dec 5, 1969, *and that death occurred at* 3:00 Am., *from the causes and on the date stated above.*

23a. SIGNATURE W. H. Arnold 012 (Degree or title)
23b. ADDRESS Burley, Idaho
23c. DATE SIGNED 12-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 8, 1969
24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery
24d. LOCATION (City, town, or county) Burley, (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 12 1969
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER Ormand F. Burch
LICENSE NO. E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5708
Local Reg. No. 2051
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 42 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1550 Almo Avenue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley,
d. STREET ADDRESS (If rural, give location): 1550 Almo Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Ethel
b. (Middle): Matilda
c. (Last): Cannell

4. DATE OF DEATH (Month) (Day) (Year): Dec. 8, 1969

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 5, 1899
9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months 9 Days 3
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tilden, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Baugh, BIRTHPLACE: Wellsville, Utah
14. MOTHER'S MAIDEN NAME: Matilda Humphrey, BIRTHPLACE: Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 519-10-8727
17. INFORMANT'S OWN SIGNATURE: Horace Cannell
ADDRESS: 1550 Almo Ave Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Adeno Carcinoma C Metastasis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Possible origin left lung.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 6 to 12 Mon.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-3-46, 19__, *to* 12-8-69, 19__, *that I last saw the deceased alive on* 12-6-69, 19__, *and that death occurred at* 10:40A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 526 MD
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Gem Memorial Gardens
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Dec. 12 1969
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F. Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 6 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 24 1969 Bureau of Vital Statistics

State File No. 5709
Local Reg. No. 2053
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
LENGTH OF STAY (In this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elba
d. STREET ADDRESS (If rural, give location) Elba

3. NAME OF DECEASED (Type or Print) a. (First) Fred b. (Middle) Joplis c. (Last) Lloyd

4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1969

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH March 11, 1896
9. AGE (In years last birthday) 73 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Ranching
11. BIRTHPLACE (State or foreign country) Elba, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William J. Lloyd BIRTHPLACE London, England
14. MOTHER'S MAIDEN NAME Rachel Wilson BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 1 3
16. SOCIAL SECURITY NO. 518-52-1558-G
17. INFORMANT'S OWN SIGNATURE Arlo P Lloyd ADDRESS Elba, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 5 years
DUE TO (c) Gen Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe Pulmonary Emphysema — 10-15 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 15, 1950, *to* Dec 14, 1969, *that I last saw the deceased alive on* Dec 14, 1969, *and that death occurred at* 5 45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE J R Kircher 283 (Degree or title) MD
23b. ADDRESS Burley Idaho
23c. DATE SIGNED 16 Dec 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/17/69
24c. NAME OF CEMETERY OR CREMATORY Elba Cemetery
24d. LOCATION (City, town, or county) (State) Elba, Idaho

DATE REC'D BY LOCAL REG. Dec. 22 1969
REGISTRAR'S SIGNATURE Ruth H. Pearson
25. EMBALMER Jerry K. Lawson
LICENSE NO. E-522

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Payne Mortuary-Burley

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 5 1970
MAR 1 1 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5710
Local Reg. No. 2055
Reg. Dist. No. 470

BIRTH NO.

RECEIVED DEC 24 1969 Vital Statistics Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): Rural Route 2 Rupert Idaho

3. NAME OF DECEASED (Type or Print): a. (First) Marion b. (Middle) Vern c. (Last) Toles

4. DATE OF DEATH (Month) (Day) (Year): Dec 14 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 12 1927

9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): La Mar Colorado

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alva Toles — BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Rosa Williams — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mrs Velma Toles — ADDRESS: Rt Rupert

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3-4 wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mel. — Yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3-11, 1969, *to* Dec 13, 1969, *that I last saw the deceased alive on* Dec 13, 1969, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M D — **23b. ADDRESS**: Burley Idaho — **23c. DATE SIGNED**: 12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Dec 17 1969 — **24c. NAME OF CEMETERY OR CREMATORY**: Rupert Cemetery — **24d. LOCATION** (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: Dec. 23 1969 — REGISTRAR'S SIGNATURE: Ruth N. Pearson

25. EMBALMER: Robert C Walk — LICENSE NO.: E 294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5711
Local Reg. No. 2056
Reg. Dist. No. 470

RECEIVED DEC 24 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (In this place): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. STREET ADDRESS (If rural, give location): 1437 A. Street

3. NAME OF DECEASED (Type or Print)
a. (First): Darwin
b. (Middle): Willard
c. (Last): Crosland Sr.

4. DATE OF DEATH (Month) (Day) (Year): Dec. 17, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 10, 1910
9. AGE (In years last birthday): 59
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 28
10b. KIND OF BUSINESS OR INDUSTRY: *********
11. BIRTHPLACE (State or foreign country): Sigard, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willard Darwin Crosland
BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Lillie Berlin
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 528-18-9408
17. INFORMANT'S OWN SIGNATURE: Sophie Crosland
ADDRESS: Heyburn, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Ventricular Fibrillation, Acute — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 6 years
DUE TO (c): Generalized Arteriosclerosis — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 20, 1963, *to* Dec 17, 1969, *that I last saw the deceased alive on* Aug 15, 1969, *and that death occurred at* 3:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. B. Kircher 283 (Degree or title): MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 19 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/20/69
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: Dec. 23, 1969
REGISTRAR'S SIGNATURE: Bill H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5712
Local Reg. No. 2054
Reg. Dist. No. 470

BIRTH NO.

RECEIVED
DEC 24 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Cassia (61)
b. CITY OR TOWN Burley
c. LENGTH OF STAY (in this place) 0
d. FULL NAME OF HOSPITAL OR INSTITUTION D.O.A. Cassia Hospital Burley Idaho (120)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka (340)
c. CITY OR TOWN Rupert Idaho
d. STREET ADDRESS (If rural, give location) 600 south 125 west, Route 2

3. NAME OF DECEASED (Type or Print)
a. (First) Fred
b. (Middle)
c. (Last) Mayer

4. DATE OF DEATH (Month) (Day) (Year) Dec 19 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Mar 9 1922

9. AGE (In years last birthday) 47
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (54)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) American Falls Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gottlieb Mayer
BIRTHPLACE Russia

14. MOTHER'S MAIDEN NAME Anna Valkenhaut
BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) U.S. Navy W.W.2

16. SOCIAL SECURITY NO. 548 34 3129

17. INFORMANT'S OWN SIGNATURE Avonell Mayer
ADDRESS Rupert

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Occlusion-circumflex branch left coronary artery — INTERVAL BETWEEN ONSET AND DEATH: few minute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Past, old mycardial infarction
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES XX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert C Walk M.D.
(Degree or title) Coroner

23b. ADDRESS 710 6th street Rupert Ida

23c. DATE SIGNED Dec 21 196[illegible]

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec 23 1969

24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery

24d. LOCATION (City, town, or county) (State) Paul Idaho

DATE REC'D BY LOCAL REG. Dec 23 1969

REGISTRAR'S SIGNATURE Ruth N. Pearson

25. EMBALMER Robert C Walk
LICENSE NO. E 294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 0 5 2011

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

DEC 31 1969

Bureau of Vital Statistics

State File No. 5713
Local Reg. No. 2060
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (In this place): 3 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1843 Overland Ave.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital (90)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Elsie	Lina	Stiens	Dec.	19,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	Widowed	April 6, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Saxon, Germany	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman Rohsberg	Germany	Lina Neithart	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	519-28-7469	William A. Stiens	Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	4123 Arteriosclerotic Myocarditis	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Atrial fibrillation	
DUE TO (c)	—	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-15-1969 *to* 12-19-1969 *that I last saw the deceased alive on* 12-18-1969 *and that death occurred at* 1 a.m., *from the causes and on the date stated above.**

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
(276) M D	Burley Id	12-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	12/22/69	Pleasant View	Burley, Idaho	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 30 1969	Bert N. Pearson	FIRM NAME: Payne Mortuary	E-389

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 13 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5714
Local Reg. No. 2064
Reg. Dist. No. 470

BIRTH NO.

JAN 13 1970

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia (61)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burley Nursing Home 290

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia (60)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Albion
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Florence		Mahoney	Dec. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Feb. 28, 1885	84	9	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife (01)		Albion, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Guiles	No data	Mary Parks	No data

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— — —		Douglas Mahoney	Albion Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Essential Hypertension — 20 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1951, *to* 27 Dec, 1969, *that I last saw the deceased alive on* 26 Dec, 1969, *and that death occurred at* 7:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] (283) MD	Burley Idaho	6 Jan 1970

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 30, 1969	Albion Masonic Cemetery, Albion,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 9, 1970	Ruth A. Pearson	Ormand Bunk	E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5715
Local Reg. No. 2063
Reg. Dist. No. 470

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Cassia (161) JAN 6 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY IN (this place) 30 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital (070)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (101)
a. STATE Idaho
b. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 196 3rd St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Sophie		Neibaur	Dec 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed	Aug. 26, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife (01)	housework	Lotzwyl, Berne, Swtz.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Johannes Sheifer	Altheim, Germany	Elsie Wolf	Lotzwyl, Berne, Swtz.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	* * *	519-36-6130	Joyce Schofield	Burley, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Pneumonia 486X	2 wks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized arteriosclerosis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-9- , 1969, *to* 12-28 , 1969, *that I last saw the deceased alive on* 10-28 , 1969, *and that death occurred at* 10:15 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Samuel J. Hammond, M.D. (647)	Box 47 Paul, Idaho	12/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal (3)	12/29/69	Feilding Mem. Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 5, 1970	Beth A Pearson	Jerry K. Lawson	E-522

FIRM NAME: Payne Mortuary-Burley

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

AUG MAR 23 1971 5 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 20 1980
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5716
Local Reg. No. 2065
Reg. Dist. No. 470

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN: Burley
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hosp. 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): 34 years
d. STREET ADDRESS (If rural, give location): 218 E. 21st Street

3. NAME OF DECEASED (Type or Print): a. (First) Clara; b. (Middle); c. (Last) Bodenhamer

4. DATE OF DEATH: (Month) Dec. (Day) 30, (Year) 1969

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 9, 1888

9. AGE (In years last birthday): 81; IF UNDER 1 YEAR Months: 4 Days: 21; IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Utah
Floral Ranch, Wayne Co.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ephraim K. Hanks
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Thisbe Read
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 519-18-7478

17. INFORMANT'S OWN SIGNATURE: Claude Bailey
ADDRESS: 2119 Oakley ave, Burley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia 4/or Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cholecystitis — years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1969, to Dec 30, 1969, that I last saw the deceased alive on 12-30, 1969, and that death occurred at 11:45A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): W R Peterson MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 1-6-70

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Jan. 3, 1970
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county): Burley, (State): Idaho

DATE REC'D BY LOCAL REG.: Jan. 9 1970
REGISTRAR'S SIGNATURE: Burl N. Pearson

25. EMBALMER: Vern B. McCulloch
LICENSE NO.: E-260
FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 6 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 6 1970
Bureau of Vital Statistics

State File No. 5717
Local Reg. No. 2062
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Cassia 160	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley; c. LENGTH OF STAY (In this place): 16 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 2	d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print)	a. (First): Kevin	b. (Middle): James	c. (Last): Hanks	4. DATE OF DEATH (Month) (Day) (Year): Dec. 31, 1969	
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married	8. DATE OF BIRTH: July 19, 1953	9. AGE (In years last birthday): 16	IF UNDER 1 YR. Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Burley, Idaho	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: James Robert Hanks	BIRTHPLACE: Salem, Utah	14. MOTHER'S MAIDEN NAME: Bonnie Koch	BIRTHPLACE: Virginia, Idaho		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service) * * *	16. SOCIAL SECURITY NO.: None	17. INFORMANT'S OWN SIGNATURE: Robert Hanks	ADDRESS: Burley, Id.		

3304

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Muscular dystrophy

INTERVAL BETWEEN ONSET AND DEATH: approx 12 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 12-30, 19 69, *to* 12-31-69, 19____, *that I last saw the deceased alive on* 12-31, 19 69, *and that death occurred at* 2:00AM *from the causes and on the date stated above.*

23a. SIGNATURE: Eugene H. Hinger (Degree or title) 239 M.O.	23b. ADDRESS: 1341 Overland Burley, Ida	23c. DATE SIGNED: 1-2-70	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 1/3/70	24c. NAME OF CEMETERY OR CREMATORY: Gem Memorial Gardens	24d. LOCATION (City, town, or county) (State): Burley, Idaho
DATE REC'D BY LOCAL REG.: Jan 5 1970	REGISTRAR'S SIGNATURE: Beth H. Pearson	25. EMBALMER: Jerry K. Lawson	LICENSE NO.: E-522

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Payne Mortuary-Burley

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5718
Local Reg. No. 2061
Reg. Dist. No. 470

RECEIVED JAN 6 1970 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hiway 80 east of Burley
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 281 Caswell, West

3. NAME OF DECEASED (Type or Print) a. (First) Darin b. (Middle) c. (Last) Sorensen

4. DATE OF DEATH (Month) (Day) (Year) Dec 31 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Nov 25 1967
9. AGE (In years last birthday) 2 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child 02
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Bountiful Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Val Sorensen BIRTHPLACE Murray Utah
14. MOTHER'S MAIDEN NAME Virginia Jensen BIRTHPLACE Delta Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Val S Sorensen ADDRESS Twin Falls Idah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8161

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) crushed skull — INTERVAL BETWEEN ONSET AND DEATH instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) automobile accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. car skidded on icy road

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) on hiway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13160 (COUNTY) (STATE) east of Burley, Cassia County, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 31 69 5:15 PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? car driven by the father, skidded on icy road.

22. *I hereby certify that I attended the deceased from* did not see alive *19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 583 (Degree or title) Coroner
23b. ADDRESS 1351 Miller Ave, Burley Ida
23c. DATE SIGNED 1-2-1970

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 1-1-1970
24c. NAME OF CEMETERY OR CREMATORY Bountiful City Cemetery
24d. LOCATION (City, town, or county) (State) Bountiful Utah

DATE REC'D BY LOCAL REG. Jan 5 1970
REGISTRAR'S SIGNATURE Beth N. Pearson
25. EMBALMER J Robert C Walk
LICENSE NO. E 294

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 0 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5719
Local Reg. No. 86
Reg. Dist. No. 210

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 23 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater 18
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (If outside place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): HARLAN
c. (Last): CAVE

4. DATE OF DEATH (Month) (Day) (Year): December 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: January 16, 1880
9. AGE (In years last birthday): 89 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unk. 00
10b. KIND OF BUSINESS OR INDUSTRY: unk.
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: unk. — BIRTHPLACE: unk.
14. MOTHER'S MAIDEN NAME: unk. — BIRTHPLACE: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unk. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unk.
17. INFORMANT'S OWN SIGNATURE: Christine Plourde Records — ADDRESS: Orofino Idaho

4369

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebrovascular accident — 11 days
DUE TO (c): Senility and Malnutrition — Several years — 11 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 2, 1969, *to* December 3 1969, *that I last saw the deceased alive on* December 3, 1969, *and that death occurred at* 4:20 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Constancio A. Cleto (Degree or title) M.D. 595 — Constancio A. Cleto
23b. ADDRESS: Box 672, Orofino, Idaho
23c. DATE SIGNED: Dec. 3, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Dec. 4, 68
24c. NAME OF CEMETERY OR CREMATORY: Hilcrest Mem. Chapel
24d. LOCATION (City, town, or county) (State): Bonners Ferry, Idaho

DATE REC'D BY LOCAL REG.: Dec. 15, 1969
REGISTRAR'S SIGNATURE: Tern M. Burger
25. EMBALMER: [signature] — LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5720
Local Reg. No. 87
Reg. Dist. No. 210

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN: Orofino
LENGTH OF STAY (in this place): 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp. 873

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
d. STREET ADDRESS (If rural, give location): Pierce

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HARRY	JAMES	MUNDS	Dec. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	married	April 20, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mill worker 17	lumber	Yankton, S. D.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Darres Munds	Unk.	May Martin	unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		x Juanita Munds	Pierce

5710

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cancer unknown
DUE TO (c) Chronic alcoholism

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 29, 1969, *to* Dec. 5, 1969, *that I last saw the deceased alive on* Dec 5, 1969, *and that death occurred at* 11:05 P., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Orofino, Idaho	Dec. 6, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 8, 69	Weippe Cem.	Weippe, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15, 1969	Lern M. Burger	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5721
Local Reg. No. 88
Reg. Dist. No. 210

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater
b. CITY OR TOWN: Orofino
c. LENGTH OF STAY (in this place): 2 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Orofino Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN: Orofino
d. STREET ADDRESS (If rural, give location): 130 C St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Betty	Carol	Gilmer	Dec. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	married	Mar. 24, 1932	37				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Clearwater, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Talbott	Idaho	Myrtle Campbell	Wn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-32-7090	Jack C. Gilmer	Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Aspiration	2-3 hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Multiple sclerosis	9-10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

340X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 19 69 *to* 12-11, 1969 *that I last saw the deceased alive on* 12-11, 1969 *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Orofino Idaho	12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 13, 69	Riverside	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 18, 1969	Vern M. Burger	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 31 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5722
Local Reg. No. 89
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater (180)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 51 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Winchester
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): ETHEL
b. (Middle): C.
c. (Last): LOWERY

4. DATE OF DEATH (Month) (Day) (Year): December 11, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 9, 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Johnston C. Calhoun — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): N/A
16. SOCIAL SECURITY NO.: 518-60-9874
17. INFORMANT'S OWN SIGNATURE Records: Christine Plowde — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8887X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary embolism with complicating acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 10 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Immobilization following fracture of right hip. — 1 1/2 months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Senility — Several years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 23, 1969, *to* December 11, 1969, *that I last saw the deceased alive on* December 11, 1969, *and that death occurred at* 4:17 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Constancio A. Cleto (Degree or title): Constancio A. Cleto 595 M.D.
23b. ADDRESS: Box 672, Orofino, Idaho
23c. DATE SIGNED: Dec. 12, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 15, 69
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1969
REGISTRAR'S SIGNATURE: Fern M. Burger
25. EMBALMER: Lyle A. Strattmann — LICENSE NO. 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5723
Local Reg. No. 91
Reg. Dist. No. 210

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clearwater (180)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (In this place) 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Orofino Convalescent Home (362)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (180)
a. STATE Idaho
b. COUNTY Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location) 504 Main St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Arthur	F.	Cooper	Dec. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	married	Aug. 24, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer (04)	agriculture	Walla Walla, Wash.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Cooper	unk.	Ellen Williams	unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-12-4289	Gracie Grogan	Spirit Lake Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	CVA (4369)	12 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Repeated CVA's	1 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 67 *to* 12-13-69 19____, *that I last saw the deceased alive on* 12-10 19 69 *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
(038)	Orofino, Idaho	12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 17, 69	Riverside	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 18, 1969	Lera M. Burger	[illegible]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5724
Local Reg. No. 90
Reg. Dist. No. 210

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY IN (this place) 9 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Greer

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orofino Convalescent Home 362
d. STREET ADDRESS (If rural, give location) Arcadian Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Florence	L.	Panska	Dec. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W	widowed	May 3, 1898	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
manager 26	nursing home	Castlerock, Wash.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Francis Worthington	Ohio	Emmaline Kight	Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	485-38-8805-B	Mrs Jack Maynard	Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Bronchopneumonia 485X	2 d
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus, CVA	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June, 1966 to 12-13, 1969 that I last saw the deceased alive on 12-13, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 038	Orofino, Idaho	12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3	Dec. 16, 69	Kamiah Cemetery	Kamiah, Lewis, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 18, 1969	Vern M. Burger	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 9 1969
JAN 1 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

State File No. 5725
Local Reg. No. ~~81~~ 92
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Clearwater 180	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pierce	c. LENGTH OF STAY (In this place): 32 yrs.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pierce-rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): own home 000	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First): LEONARD	b. (Middle):	c. (Last): STEWART	4. DATE OF DEATH (Month) (Day) (Year): Dec. 25, 1969	
5. SEX: M	6. COLOR OR RACE: W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: Nov. 29, 1905	9. AGE (In years last birthday): 64 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): logger 17	10b. KIND OF BUSINESS OR INDUSTRY: lumber	11. BIRTHPLACE (State or foreign country): Walla Walla, Wash.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: William Stewart	BIRTHPLACE: Mo.	14. MOTHER'S MAIDEN NAME: Effie	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-03-2092	17. INFORMANT'S OWN SIGNATURE: X Gary J Stewart	ADDRESS: Pierce	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 30 Oct 69	19b. MAJOR FINDINGS OF OPERATION: Carcinoma of colon c̄ metastases	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 30 Oct *, 19*69*, to* 25 Dec *, 19*69*, that I last saw the deceased alive on* 21 Oct *, 19*69*, and that death occurred at* 11:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE: 8971 David W. Hensen Sr. (Degree or title) MD	23b. ADDRESS: 307 St John's Way	23c. DATE SIGNED: 29 Dec 69	
24a. BURIAL, CREMATION, REMOVAL (Specify): burial	24b. DATE: Dec. 30, 69	24c. NAME OF CEMETERY OR CREMATORY: Weseman	24d. LOCATION (City, town, or county) (State): Orofino, Idaho
DATE REC'D BY LOCAL REG.: Jan. 9, 1970	REGISTRAR'S SIGNATURE: Fern M. Burger	25. EMBALMER: Lyle A. Strottmann	LICENSE NO.: 476

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 16 1970
JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5726
Local Reg. No. 93
Reg. Dist. No. 210

BIRTH NO.

RECEIVED JAN 13 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (In this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 180
a. STATE Idaho
b. COUNTY Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ahsahka
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	W.	ARBUCKLE	Dec. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	married	Sept. 11, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 07		Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel Arbuckle	Ill.	Anna Spencer	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes WW 2 4	518-42-0607	Frank Arbuckle	Brewster, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Pulmonary Edema 4/23

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart failure
DUE TO (c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 24 Dec, 1969, to 31 Dec, 1969, that I last saw the deceased alive on 31 Dec, 1969, and that death occurred at 1:30 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
340	Orofino Idaho	5 Jan 70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Jan. 5, 1970	Lewis-Clark Mem. G.	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 9, 1970	Vern M. Burger	Lyle C. Stutzman	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 16 1970
FEB 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

BIRTH NO. 69-12458

Certificate of Death

RECEIVED STATE OF IDAHO

DEC 31 1969

Bureau of Vital Statistics

State File No. 5727
Local Reg. No. 83
Reg. Dist. No. 380 391

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (In this place): [illegible]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Mem. Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hammett
d. STREET ADDRESS (If rural, give location): Labor Camp - Apt 1

3. NAME OF DECEASED (Type or Print): a. (First) EARL b. (Middle) CLAYTON c. (Last) NOTESTINE IV.

4. DATE OF DEATH: (Month) (Day) (Year) Nov. 14, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Nov. 12, 1959

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days: 2 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 0x

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mountain Home, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Randal Clayton Notestin BIRTHPLACE: Californbin

14. MOTHER'S MAIDEN NAME: Patricia Lee LaGrande BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE ADDRESS: X Randy Notestine Hammett, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7762 Respiratory Distress Syndrome — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donna L Bell MD

23b. ADDRESS: Mountain Home, Idaho

23c. DATE SIGNED: 11/25/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Dec 30 1969

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: H. Wendell Humphreys LICENSE NO. E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 31 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5728
Local Reg. No. 86
Reg. Dist. No. 280 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 680

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Prairie
d. STREET ADDRESS (If rural, give location) Prairie

3. NAME OF DECEASED (Type or Print)
a. (First) ORA
b. (Middle) LINDSEY
c. (Last) ENGELMAN

4. DATE OF DEATH (Month) (Day) (Year) December 6, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 7, 1896
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Superintendent 08
10b. KIND OF BUSINESS OR INDUSTRY Highway Mtnce.
11. BIRTHPLACE (State or foreign country) Castle Rock, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME C. J. Engelman — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Annie E. Rich — BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War 13
16. SOCIAL SECURITY NO. 518-24-8362
17. INFORMANT'S OWN SIGNATURE Mrs. Ora L. Engelman — ADDRESS Prairie

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Kidney — INTERVAL BETWEEN ONSET AND DEATH Months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1968
19b. MAJOR FINDINGS OF OPERATION As above
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1969 *to* Dec 6, 1969, *that I last saw the deceased alive on* Dec 6, 1969, *and that death occurred at* 10:30 *m, from the causes and on the date stated above.*

23a. SIGNATURE Malone W. Koelsch MD (Degree or title) 289
23b. ADDRESS Mountain Home Idaho
23c. DATE SIGNED Dec 24 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/9/69
24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery
24d. LOCATION (City, town, or county) (State) Mountain Home, Idaho

DATE REC'D BY LOCAL REG. Dec 30 1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Mortuary

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 11 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5729
Local Reg. No. 84
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 3 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 360 North 5th East

3. NAME OF DECEASED (Type or Print)
a. (First): EULA
b. (Middle): MAXINE
c. (Last): ESTABROOK

4. DATE OF DEATH (Month) (Day) (Year): December 5, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 19, 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Secretary 08
10b. KIND OF BUSINESS OR INDUSTRY: Civil Service
11. BIRTHPLACE (State or foreign country): Lebanon, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James M. Palmer — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Elsie Jones — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 542-22-7583
17. INFORMANT'S OWN SIGNATURE: Fred Palmer — ADDRESS: Grand View

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchoobstructive disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary emphysema — years
DUE TO (c) Cor Pulmonale due to #1 — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death
Acute pneumonites — days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9, 1957, *to* Dec 6, 1969, *that I last saw the deceased alive on* 12-6, 1969, *and that death occurred at* 9:29 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Malcolm W. Scotch M.D. Mountain Home Idaho — **23b. ADDRESS**: 281 — **23c. DATE SIGNED**: Dec 24 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 12/9/69
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Grandview, Idaho

DATE REC'D BY LOCAL REG.: Dec 30 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Neil Humphreys — **LICENSE NO.**: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Certificate of Death

STATE OF IDAHO

State File No. 5730
Local Reg. No. 85
Reg. Dist. No. 380 391

BIRTH NO. DEC 3 1 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Nursing Home 356

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Mountain Home
d. STREET ADDRESS (If rural, give location) Canyon Creek Road

3. NAME OF DECEASED (Type or Print)
a. (First) JOE
b. (Middle)
c. (Last) JANOUSEK

4. DATE OF DEATH (Month) (Day) (Year) Dec. 6, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 17, 1884
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custom Threshing of
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Jennings, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Clarance D Janousek — ADDRESS Boise, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes Med — years; CSHD — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6, 1969, *to* Dec 6, 1969, *that I last saw the deceased alive on* Dec 5, 1969, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE Malone N Welsh 289 (Degree or title)
23b. ADDRESS Mountain Home Idaho
23c. DATE SIGNED Dec 24 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/10/69
24c. NAME OF CEMETERY OR CREMATORY Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State) Mountain Home, Idaho

DATE REC'D BY LOCAL REG. Dec 30 1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signature of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 11 1983

MAY 11 1987

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 5731
Local Reg. No. 87
Reg. Dist. No. 380 391

69-12471 RECEIVED STATE OF IDAHO
BIRTH NO. Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ELMORE DEC 31 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Mtn Home AFB
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 67 TAC Hosp, Mt Home AFB, ID

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Home, Idaho 83648
d. STREET ADDRESS (If rural, give location) 440 N. 3rd W.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Steven		Taysom	December 8 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	CAU	/	8 December 1969				2	25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mtn Home AFB, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Stanford H. Taysom	American Falls, Idaho	Nona L. Hardy	Murray, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Stanford H. Taysom	440 N. 3rd E, Mtn Home, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs 25min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8 December, 1969, *to* 8 December 1969, *that I last saw the deceased alive on* 8 December, 19 69, *and that death occurred at* 2300 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
DOUGLAS P. NORMAN, CAPT USAF MC MD	Mtn Home AFB, Idaho	8 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/11/69	Mtn. View Cemetery	Mtn. Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 30 1969			E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 5732
Local Reg. No. 88
Reg. Dist. No. 380 391

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Elmore
DEC 31 1969
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Dixie
LENGTH OF STAY (in this place): 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Camas Reservoir
d. STREET ADDRESS (If rural, give location): 160 North 12th East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WALTER	RAY	HOLGATE	December 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct. 1, 1928	41				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Businessman 22
10b. KIND OF BUSINESS OR INDUSTRY: Radio, TV repair
11. BIRTHPLACE (State or foreign country): Redmond, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ray Holgate
BIRTHPLACE: Oregon
14. MOTHER'S MAIDEN NAME: Lucille Wilson
BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): 1945 - 1966
16. SOCIAL SECURITY NO.: 542-24-9778
17. INFORMANT'S OWN SIGNATURE: Bobby D Holgate
ADDRESS: Big Piney, Wyo.

8330

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Accidental drowning
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Reservoir 18
21c. (CITY, TOWN, OR TOWNSHIP) 3200 **(COUNTY)** **(STATE)**: Rural - Dixie, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12/9/69 9:45 PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Snowmobile broke thru ice and victim drowned

22. *I hereby certify that I attended the deceased from* Did not see alive. *, 19 , that I last saw the deceased alive on , 19 , and that death occurred at m., from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith (Degree or title): Coroner
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 12/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/12/69
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Dec 30 1969
REGISTRAR'S SIGNATURE: T Anderson
25. EMBALMER: H. Neil Humphreys
LICENSE NO.: E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 1 0 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5733
Local Reg. No. 89
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 3 1 1969
Bureau of Vital Statistics

1. PLACE OF DEATH 200
a. COUNTY Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Home AFB
c. LENGTH OF STAY (in this place) 34
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 67TAC Hosp Mtn Home AFB, ID 077

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Home
d. STREET ADDRESS (If rural, give location) 1035 N. 7th E.

3. NAME OF DECEASED (Type or Print)
a. (First) Lawrence
b. (Middle) Frank
c. (Last) Catalano

4. DATE OF DEATH (Month) (Day) (Year) December 13 1969

5. SEX Male
6. COLOR OR RACE Cau
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 4 Feb 24
9. AGE (In years last birthday) 45 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY Insurance Agent
11. BIRTHPLACE (State or foreign country) Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Catalano — BIRTHPLACE Riberia, Italy
14. MOTHER'S MAIDEN NAME Grace Unknown — BIRTHPLACE Menfi, Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) 24 Apr 42-1APR63
16. SOCIAL SECURITY NO. 089-16-6774
17. INFORMANT'S OWN SIGNATURE Geraldine M. Catalano — ADDRESS 1035 N. 7th E., Mtn Home, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

188X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Disseminated Carcinoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Bladder
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 13, 1969, *to* Dec 13, 1969, *that I last saw the deceased alive on* Dec 13, 1969, *and that death occurred at* 2045 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Richard W. Worst (Degree or title) RICHARD W. WORST, CAPT USAF MC 585 MD
23b. ADDRESS Mtn Home AFB, ID
23c. DATE SIGNED 13 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/16/69
24c. NAME OF CEMETERY OR CREMATORY Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State) Mountain Home, Idaho

DATE REC'D BY LOCAL REG. Dec 30 1969
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER H. Ned Humphrey
LICENSE NO. E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5734
Local Reg. No. 82
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED
DEC 31 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 960 East 17th North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 960 East 17th North

3. NAME OF DECEASED (Type or Print)
a. (First): FRANCIS
b. (Middle): ADDISON
c. (Last): McGLONE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 15, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 27, 1903
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Major 05
10b. KIND OF BUSINESS OR INDUSTRY: U.A.F.
11. BIRTHPLACE (State or foreign country): Kokomo, Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Addison E. McGlone — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Julia McCart — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 6/6/42-8/15/687
16. SOCIAL SECURITY NO.: 308-09-8392
17. INFORMANT'S OWN SIGNATURE: Martha J McGlone — ADDRESS: Mtn. Home, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Emphysema — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cirrhosis of the Liver.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation only, *19*__, *to* __, *19*__, *that I last saw the deceased alive on* __, *19*__, *and that death occurred at* 9:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith 583 4 (Degree or title): Coroner
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 12/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/18/69
24c. NAME OF CEMETERY OR CREMATORY: Kokomo, Indiana
24d. LOCATION (City, town, or county) (State): Kokomo, Indiana

DATE REC'D BY LOCAL REG.: Dec 30 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Neil Humphrey — LICENSE NO. E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5735
Local Reg. No. 5
Reg. Dist. No. 380 391

Certificate of Death

STATE OF IDAHO

BIRTH NO. 4

RECEIVED JAN 13 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Elmore Mem. Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Douglas 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grand Coulee
d. STREET ADDRESS (If rural, give location): 302 Partello

3. NAME OF DECEASED (Type or Print)
a. (First): CELINA
b. (Middle): JESSIE
c. (Last): ST. JOHN

4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 10, 1894
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Sprada, California
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Peter Lambert — BIRTHPLACE: France
14. MOTHER'S MAIDEN NAME: Rosalee Provincal — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Yvonne C. Spillman — ADDRESS: Deming, N.M.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* 12-23, 1969, *and that death occurred at* 6:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith 553 — (Degree or title): Coroner
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/23/69
24c. NAME OF CEMETERY OR CREMATORY: Grand Coulee, Wash.
24d. LOCATION (City, town, or county) (State): Grand Coulee, Washington

DATE REC'D BY LOCAL REG.: Jan 7 1970
~~REGISTRAR'S SIGNATURE~~: [signature]
25. EMBALMER: H. Neil Humphreys — LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 14 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5736
Local Reg. No. 49
Reg. Dist. No. 650

RECEIVED DEC 15 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 221
a. COUNTY Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony m
c. LENGTH OF STAY (in this place) 8 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Teton City
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Delories
b. (Middle) "Chub"
c. (Last) Jensen

4. DATE OF DEATH (Month) (Day) (Year) Dec., 7, 1969

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH 9 Dec 6903
9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR Months 11 Days 28 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Teton City, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Jensen — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Jane Ann Donaldson — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 518-36-3745 A
17. INFORMANT'S OWN SIGNATURE Pearl Miller — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 8 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 6, 1969, *to* Dec 7, 1969, *that I last saw the deceased alive on* Dec 7, 1969, *and that death occurred at* 4 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Lloyd Barrett MD 030 (Degree or title)
23b. ADDRESS St. Anthony, Idaho
23c. DATE SIGNED 10 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10 Dec 69
24c. NAME OF CEMETERY OR CREMATORY Teton-Newdale Cemetery
24d. LOCATION (City, town, or county) (State) Sugar City, RFD, Idaho

DATE REC'D BY LOCAL REG. 11 Dec 69
REGISTRAR'S SIGNATURE M. D. Hansen
25. EMBALMER M. D. Hansen — LICENSE NO. E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5737
Local Reg. No. 50
Reg. Dist. No. 650

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 30 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY FREMONT 221
b. CITY OR TOWN ST. ANTHONY
c. LENGTH OF STAY (in this place) 11 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FREMONT GENERAL HOSPITAL 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY FREMONT 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. ANTHONY
d. STREET ADDRESS (If rural, give location) 327 North 5 West

3. NAME OF DECEASED (Type or Print)
a. (First) JESSE
b. (Middle) FRANKLIN
c. (Last) GRIFFIN

4. DATE OF DEATH (Month) (Day) (Year) Dec., 14, 1969

5. SEX MALE
6. COLOR OR RACE CAUCASIAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 19 Sept 1895
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 04
10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED
11. BIRTHPLACE (State or foreign country) CLARKSTON, UTAH
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME THOMAS GRIFFIN — BIRTHPLACE WORCESTER, ENGLAND
14. MOTHER'S MAIDEN NAME MARTHA GOVER — BIRTHPLACE SALT LAKE CITY, UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-36-6623
17. INFORMANT'S OWN SIGNATURE Thomas G. Harrop — ADDRESS Rexburg, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 22 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1969, *to* Dec, 1969, *that I last saw the deceased alive on* Dec 14, 1969, *and that death occurred at* 7:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE 030 Lloyd Barrett, M.D. (Degree or title)
23b. ADDRESS St/ Anyhony, Idaho
23c. DATE SIGNED 19 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 18 Dec 69
24c. NAME OF CEMETERY OR CREMATORY Little Butte Cemetery
24d. LOCATION (City, town, or county) (State) Annis, Jefferson, Idaho

DATE REC'D BY LOCAL REG. 20 Dec 69
REGISTRAR'S SIGNATURE M. D. Hansen
25. EMBALMER M. D. Hansen — LICENSE NO. E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HANSEN MEMORIAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 9 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5738
Local Reg. No. 51
Reg. Dist. No. 650

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 221
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bridge Street & 1st North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) 15 West 2nd North

3. NAME OF DECEASED (Type or Print)
a. (First) JAMES
b. (Middle) ALMA
c. (Last) THOMSON

4. DATE OF DEATH (Month) (Day) (Year) Dec 24, 1969

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 18, 1894
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 28
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Teton, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas M. Thomson — BIRTHPLACE Salt Lake City, Ut
14. MOTHER'S MAIDEN NAME Jean Nibley — BIRTHPLACE Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW I 3
16. SOCIAL SECURITY NO. 519-12-2365 A
17. INFORMANT'S OWN SIGNATURE William M. Thomson — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8147

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lacerated Thoracic Aorta — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Crushed Chest
DUE TO (c) 2° to a Car Pedestrian Accident

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bridge St & 1 N 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Anthony, Fremont, Idaho 13221
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 24, 1969 6 P.M.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Struck by car as he was crossing street in pedestrian lane

22. *I hereby certify that I attended the deceased from* D. O. A. *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Paul Romell 583 (Degree or title) Coroner
23b. ADDRESS St. Anthony, Idaho
23c. DATE SIGNED 26 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 29 Dec 69
24c. NAME OF CEMETERY OR CREMATORY Teton-Newdale Cemetery
24d. LOCATION (City, town, or county) (State) Sugar City, RFD, Idaho

DATE REC'D BY LOCAL REG. 29 Dec 69
REGISTRAR'S SIGNATURE M. D. Hansen
25. EMBALMER M. D. Hansen — LICENSE NO. E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 2 1 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 2 0 1995

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5739
Local Reg. No. 31
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED 231 DEC 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): 3 1/2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION: Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 703 East Park

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	McKinley	Scybert	Dec. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Feb. 24, 1896	73	9	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
dairyman c4	dairy	Amoret, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gerard Washington Scybert	unknown	Catherine Ray	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	518-07-3463	X Mrs Paul E Bryant	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4410

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Dissecting Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: Sev. weeks

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchial Asthma

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-24-69, 19, *to* Dec 1, 19 69, *that I last saw the deceased alive on* Dec 1, 1969, *and that death occurred at* 10:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B Jewell M.D.	1024 E. Locust, Emmett, Ida	12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 5, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-5-69	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 2 0 1994 DEC 9 1969

DEC 1 2 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 12 1969 Bureau of Vital Statistics

State File No. 5740
Local Reg. No. 33
Reg. Dist. No. 34-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 12days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gem 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Route 1 East 4th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Frank	Levi	McNealy	December 3, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	September 18, 1901	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
carpenter 11	building	Smith County, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin R. McNealy	Smith Co., Kansas	Katherine Fail	Brown Co., Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518 09 9396	X Albert R. McNealy	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1579

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Ca of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chest metastasis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1945 to 12-3, 19 69 that I last saw the deceased alive on 3 Dec, 19 69 and that death occurred at 1 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Emmett, Ida.	5 Dec. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 6, 1969	Emmett	Emmett Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 9, 1969	[signature]	[signature]	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 4 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5741
Local Reg. No. 34
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED DEC 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
LENGTH OF STAY (In this place) 47 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Max	M.	Hosoda	Dec. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	Japanese	married	Aug. 25, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farm	Hiroshima, Ken, Japan	Japan

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ryosaburd Hosoda	Hiroshima, Ken, Japan	Riima Kemiyamac	Hiroshima, Ken, Japan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-46-1143	Yoshimi Hosoda	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4380

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hypertensive C-V

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) disease C C V A
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 14yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* — , 19 , *to* 12-9 , 19 69 , *that I last saw the deceased alive on* 12-9 , 19 69 , *and that death occurred at* 2:35A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.		12-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 12, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-15-69			E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 18 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5742
Local Reg. No. 35
Reg. Dist. No. 340 - 341

BIRTH NO.

RECEIVED DEC 19 1969 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY 231 Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 2 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 506 W. 4th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	H.	Rolfe	Dec. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed	March 30, 1879	90	8	11		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 17	lumber	Hillsboro, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles B. Rolfe	Ohio	Elvira Davidson	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-07-3107	Glenn W Beatty	Emmett Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio-sclerotic cardiovascular disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-28, 1958, to 12-11, 1969, that I last saw the deceased alive on 12-10, 1969, and that death occurred at 8:30A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harmon E. Halverson MD	Emmett, Idaho	12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 16, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 17, 1969	Glenn W Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 19 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED DEC 19 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5743
Local Reg. No. 36
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 231 Gem	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett; c. LENGTH OF STAY (In this place) 1 week	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085	d. STREET ADDRESS (If rural, give location) Mounted Route

3. NAME OF DECEASED (Type or Print) a. (First) Harry	b. (Middle) William	c. (Last) Rogers	4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1969			
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 18, 1887	9. AGE (In years last birthday) 81	IF UNDER 1 YR. Months 11 Days 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mill wright 17	10b. KIND OF BUSINESS OR INDUSTRY lumber	11. BIRTHPLACE (State or foreign country) Kirwin, Kansas	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Monroe Rogers	BIRTHPLACE Illinois	14. MOTHER'S MAIDEN NAME Maude Elva Crist	BIRTHPLACE Ohio			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-07-3341	17. INFORMANT'S OWN SIGNATURE X Wayne M. Rogers	ADDRESS Sumpter Ore.			

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	(1) Coronary occlusion	7 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	(2) Perforated colon (?) c peritonitis	1 day
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1945, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 8 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 184 (Degree or title)	23b. ADDRESS Emmett, Ida.	23c. DATE SIGNED 16 Dec. 1969	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Dec. 17, 1969	24c. NAME OF CEMETERY OR CREMATORY Emmett	24d. LOCATION (City, town, or county) Emmett, Idaho (State)
DATE REC'D BY LOCAL REG. Dec. 17 1969	REGISTRAR'S SIGNATURE Jean A Beatty	25. EMBALMER Glenn W Beatty	LICENSE NO. E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 19 1969

MAR 17 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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R.

Certificate of Death
STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 5744
Local Reg. No. 37
Reg. Dist. No. 340 341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231 DEC 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 634 E. 2nd

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Jackson	Christison	Dec. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	March 1, 1894	75	9	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supervisor 08	County Road Dept.	Lebo, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ernest Tolan Christison	Kansas	Maggie T. Cox	Lebo, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WWI	518-12-0235	X Leon J Christison	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) PROBABLE ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) SEVERE ARTERIOR SCLEROSIS — YEARS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4 DAY POST OPERATIVE FROM LAPAROTOMY FOR CHRONIC & RECURRENT ACUTE OBSTRUCTION SECONDARY TO ADHESIONS OF THE CECUM AND TERMINAL ILEUM DUE TO PREVIOUS PERITONITIS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12/10/69		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ____, 1960 to Dec 15, 1969, that I last saw the deceased alive on Dec 15, 1969 and that death occurred at 6:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald P. Faulkner M.D. 429	Emmett Idaho	12/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 18, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-17-69	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED DEC 29 1969 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5745
Local Reg. No. 40
Reg. Dist. No. 340 341

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Gem 231	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett; c. LENGTH OF STAY (In this place) 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085	d. STREET ADDRESS (If rural, give location) Mounted Route

3. NAME OF DECEASED (Type or Print) a. (First) Joseph	b. (Middle) Kirk	c. (Last) Strang	4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1969	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH March 24, 1887	9. AGE (In years last birthday) 83; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping clerk 17	10b. KIND OF BUSINESS OR INDUSTRY lumber	11. BIRTHPLACE (State or foreign country) Parkville, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David G. Strang	BIRTHPLACE Plate City, Mo.	14. MOTHER'S MAIDEN NAME Leora Hoy	BIRTHPLACE Plate City, Mo.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI 3	16. SOCIAL SECURITY NO. 518-09-1794	17. INFORMANT'S OWN SIGNATURE X Mrs. Lulu Strang	ADDRESS	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____ *19*____, *to* 12-17, *19* 69, *that I last saw the deceased alive on* _____, *19*____, *and that death occurred at* 7:35 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 184 (Degree or title)	23b. ADDRESS Emmett, Ida.	23c. DATE SIGNED 20 Dec. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Dec. 20, 1969	24c. NAME OF CEMETERY OR CREMATORY Emmett	24d. LOCATION (City, town, or county) (State) Emmett, Idaho
DATE REC'D BY LOCAL REG. 12-21-69	REGISTRAR'S SIGNATURE Jean A Beatty	25. EMBALMER [signature]	LICENSE NO. E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969
MAY 2 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

State File No. 5746
Local Reg. No. 38
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
LENGTH OF STAY (In this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) General Delivery

3. NAME OF DECEASED (Type or Print) a. (First) Katherine b. (Middle) c. (Last) Jones

4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH March 21, 1900

9. AGE (In years last birthday) 69
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook 21

10b. KIND OF BUSINESS OR INDUSTRY restaurant

11. BIRTHPLACE (State or foreign country) Switz Co., Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Isaac Mellen, Jr.
BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Nettie McSwain
BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 451-22-9790

17. INFORMANT'S OWN SIGNATURE X Floyd W. Dunlap
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 2509 ACUTE ANTERIOR MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 8 DAYS

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) MELLITUS & EPISODES OF DIABETIC COMA & — 6 YEARS
DUE TO (c) HYPOGLYCEMIA. — 8 DAYS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NEPHRITIS & UREMIA — 8 DAYS

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19 67, to DEC 17, 19 69, that I last saw the deceased alive on DEC 17, 19 69, and that death occurred at 6:55 A m., from the causes and on the date stated above.

23a. SIGNATURE Ernest P. Faulkner (Degree or title) MD

23b. ADDRESS Emmett Idaho

23c. DATE SIGNED 12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Dec. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY Emmett

24d. LOCATION (City, town, or county) Emmett, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 22, 1969

REGISTRAR'S SIGNATURE Jean A Beatty

25. EMBALMER

LICENSE NO. E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate is being corrected.

bf 4-30-70

Certificate of Death
STATE OF IDAHO

State File No. 5747
Local Reg. No. 39
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED DEC 29 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 405 East 3rd

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	A.	Stalker	Dec. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	March 25, 1884	85	8 / 23	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
postal clerk 08	Post Office	Franklin, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alexander Stalker	unknown	Emmaline Nelson	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-56-5660T	X Mrs. Willard Hoffman	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4369 CEREBRAL VASCULAR ACCIDENT		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) WITH HEMIPLEGIA LEFT & COMA		5 DAYS
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July, 1969, to Dec 18, 1969, that I last saw the deceased alive on DEC. 18, 1969, and that death occurred at 8:40 AM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donnell P. Parkinson MD	Emmett Idaho	12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 20, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 22, 1969	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 1 1 1970

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MAR 2 3 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5743
Local Reg. No. 41
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 20 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 818 Circle Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 818 Circle Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lillian		Little	Dec. 20, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	married	June 20, 1894	75	6	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Coyote, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Clayton	England	Emma Bull	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-32-7082A	X [illegible]	

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 5, 1963, to Dec 20, 1969, that I last saw the deceased alive on Dec 2, 1969, and that death occurred at 4 05 a.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B. Jewell MD	1024 E. Locust, Emmett, Idaho	12-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 23, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-26-69	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 2 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5749
Local Reg. No. 48
Reg. Dist. No. 340-34

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 23 1
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 185

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 23
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 712 So. Boise

3. NAME OF DECEASED (Type or Print) a. (First) Arthur b. (Middle) c. (Last) Cochran

4. DATE OF DEATH (Month) (Day) (Year) Dec. 22, 1969

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH April 28, 1888

9. AGE (In years last birthday) 81
IF UNDER 1 YR. Months 7 Days 24
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fireman

10b. KIND OF BUSINESS OR INDUSTRY municipal

11. BIRTHPLACE (State or foreign country) San Francisco, Calif.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Cochran
BIRTHPLACE Carlton, New Brunswick

14. MOTHER'S MAIDEN NAME Anna Montague
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 569-30-0095

17. INFORMANT'S OWN SIGNATURE X Kathryn M Cochran
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

149X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of pharanx with metastasis to brain — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-23 *,* 19 68 *, to* 12-22 *,* 19 69 *, that I last saw the deceased alive on* _____ *,* 19 ____ *, and that death occurred at* 2:50 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Thomas E. Halverson MD (Degree or title) 241

23b. ADDRESS Emmett, Idaho 83617

23c. DATE SIGNED 12-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3

24b. DATE 12-23-69

24c. NAME OF CEMETERY OR CREMATORY Valente-Marini Perato & Co.

24d. LOCATION (City, town, or county) (State) San Francisco, Calif.

DATE REC'D BY LOCAL REG. 1-5-70

REGISTRAR'S SIGNATURE Jean A Beatty

25. EMBALMER Glenn W Beatty

LICENSE NO. E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5750
Local Reg. No. 42
Reg. Dist. No. 340 341

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 231 Gem DEC 30 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Rt. 1,

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Orvil	Cunningham	Dec. 22, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Nov. 26, 1894	75	1	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 64	farm	LaGrange, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John W. Cunningham	Wisconsin	Addie Moorehouse	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WWI 3	519-42-5817	X Wilma Rinke	Astoria, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4709

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary Occlusion	1 hr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec 8, 1959, *to* Dec 22, 1969, *that I last saw the deceased alive on* Dec 22, 1969, *and that death occurred at* 7:10P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B. Jewell MD 26C	1024 E. Locust, Emmett, Idaho	12-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 26, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-26-69	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

JAN 5 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5751
Local Reg. No. 45
Reg. Dist. No. 340-341

RECEIVED JAN 6 1970 231 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Gem b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett c. LENGTH OF STAY (In this place) 24 years d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 409 East 4th	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gem 231 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett d. STREET ADDRESS (If rural, give location) 409 East 4th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Raymond	George	Beck	Dec. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	May 18, 1892	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer 10	railroad	Lehi, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
August Drusell	Germany	Beck	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE & ADDRESS
No	A-851393	X Helen J. Smith

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disesse
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 21 1960 *to* Dec 25, 1969 *that I last saw the deceased alive on* Dec 24, 1969 *and that death occurred at* 9:30 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Wm B. Jewell MD. 260 (Degree or title)	1024 E. Locust, Emmett, Ida	12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 29, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-31-69	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 6 1970

JUL 1 2 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5752
Local Reg. No. 43
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 231 Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Emmett Valley Manor 302

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE California 05
b. COUNTY San Mateo 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) San Carlos
d. STREET ADDRESS (If rural, give location) 268 Park Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Myrtle	H.	Stayton	Dec. 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
female	white	married	Oct. 4, 1885	84	2 21	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Wallowa Co., Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elmer E. Hayden	Illinois	Eliza Huffman	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	536-66-6006T	X Wm. E. Stayton	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 mins

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) Acute Bronchitis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pemphigus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* October 6 1967 *, to* Dec 25 , 1969 *, that I last saw the deceased alive on* Dec 24 , 1969 *, and that death occurred at* 4:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B. Jewell	260 M.D.	1024 E. Locust, Emmett, Idaho	12-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal 3	Dec. 27, 1969	Mountain View Cemetery	Oakland, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-26-69	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 1 2 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5753
Local Reg. No. 44
Reg. Dist. No. 340 341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 230
JAN 5 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett Rural
Bureau of Vital Statistics
LENGTH OF STAY (in this place): 5 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Gem 230
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett Rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WALTER	ARLIN	CASTER	Dec. 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Apr. 15, 1914	55	8	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction worker 11
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Van Tassle, Wyoming
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin D. Caster — BIRTHPLACE: St. Louis, Mo.
14. MOTHER'S MAIDEN NAME: Lydia L. Walkup — BIRTHPLACE: Tarkio, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Yes-WW 11 4
16. SOCIAL SECURITY NO.: 519-22-2693
17. INFORMANT'S OWN SIGNATURE: X Mrs Walter A. Caster — ADDRESS: Emmett

1579

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): CA of pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 184	MD	Emmett, Ida.	29 Dec. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-30-1969	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.: Dec. 31, 1969
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463
FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 11 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 23 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 9 1986

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED JAN 6 1970 Bureau of Vital Statistics

State File No. 5754
Local Reg. No. 46
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
LENGTH OF STAY (In this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION Rt. 3, Box 42 DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Rt. 3, Box 42

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	Francis	Niccolls	Dec. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	May 19, 1889	80	7 / 9	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farm	Montrose, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James F. Niccolls	Ohio	Mary C. McDonald	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes N WWI 3	518-30-0735	X Mrs Letha M Martell	Caldwell Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	self inflicted gunshot in head	mins.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

955 X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
2 Suicide	home 31	Emmett 13230 Gem Idaho	m.		self inflicted

22. *I hereby certify that I attended the deceased from* never *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glenn W Beatty	83 4 Coroner Gem County	Emmett, Idaho	12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 3	Jan. 2, 1970	Star	Star, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-31-69	Glenn W Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 7 1970

FEB 18 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 20 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5755
Local Reg. No. 47
Reg. Dist. No. 340 - 341

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 25 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 811 East 2nd

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	Hahn	Wills	Dec. 28, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed	Oct. 16, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
carpenter & painter 21	contracting	Watscka, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Wills	Indiana	Aletha Belle Hahn	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-05-1614	X Agnes Wills	Star

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4270 Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 mos

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) following Pneumonia*
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec 2, 19 69, *to* Dec 28, 19 69, *that I last saw the deceased alive on* Dec 28, 19 69, *and that death occurred at* 4:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ronald P. Rawlinson 429 MD	Emmett Idaho	12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 31, 1969	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-31-69	Joan A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5756
Local Reg. No. 3183
Reg. Dist. No. 420

BIRTH NO.

RECEIVED DEC 12 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1038 Wyoming St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 1042 Wyoming St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ernest	Allen	Admire	Dec. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	May 4, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Painter 21	Painting	Liberty, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no -----	507-05-0817	H.C. Admire	Gooding, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 Minutes.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* Dec. 2, 1969, 19____, *that I last saw the deceased alive on* November 13 19 69, *and that death occurred at* 6:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Marion D. Thompson MD (Degree or title)	Gooding, Idaho	Dec. 3, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-5-1969	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 10, 1969	Eddie G. Leach	Eddie G. Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 21 1980

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DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED DEC 22 1969 Bureau of Vital Statistics

State File No. 5757
Local Reg. No. 3184
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Gooding 240	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding - Rural; c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding - 2 so. 13/4 W.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence-2 M.So 1¾ M.W. 000	d. STREET ADDRESS (If rural, give location) Route # 2

3. NAME OF DECEASED (Type or Print)	a. (First) Milam	b. (Middle) Bird	c. (Last) Divelbiss	4. DATE OF DEATH (Month) (Day) (Year) Dec. 15, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH July 1, 1895	9. AGE (In years last birthday) 74; IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired .7	10b. KIND OF BUSINESS OR INDUSTRY Lumberman	11. BIRTHPLACE (State or foreign country) Braymer, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bird R. Divelbiss	BIRTHPLACE Missouri	14. MOTHER'S MAIDEN NAME Susan Brownen	BIRTHPLACE Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 1 3	16. SOCIAL SECURITY NO. 518-18-6943	17. INFORMANT'S OWN SIGNATURE J. S. Divelbiss	ADDRESS Gooding, Idaho	

1621

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchogenic Ca of Rt Lung with wide spread metastasis — INTERVAL BETWEEN ONSET AND DEATH 7 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphy Sema

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-10-69, 19___, *to* 12-15-69, 19___, *that I last saw the deceased alive on* 12-10-69, 19___, *and that death occurred at* 10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Douglas Ohmitt Jr MD 889 (Degree or title)	23b. ADDRESS 134 W 4th Ave Gooding	23c. DATE SIGNED 12/17/69.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-20-1969	24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery	24d. LOCATION (City, town, or county) Buhl, (State) Idaho
DATE REC'D BY LOCAL REG. Dec. 17, 1969	REGISTRAR'S SIGNATURE Eddie E. Leach	25. EMBALMER Eddie E. Leach	LICENSE NO. E-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 9 1970

MAR 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 13 1970 Bureau of Vital Statistics

State File No. 5758
Local Reg. No. 3186
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Gooding 240	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell LENGTH OF STAY (In this place) 36 Days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253	d. STREET ADDRESS (If rural, give location) 534 7th Ave. West

3. NAME OF DECEASED (Type or Print)	a. (First) Edward	b. (Middle) C	c. (Last) Walch	4. DATE OF DEATH (Month) (Day) (Year) Dec. 29, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Dec. 6, 1902	9. AGE (In years last birthday) 67 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman 09	10b. KIND OF BUSINESS OR INDUSTRY Gas Company	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emil Walch	BIRTHPLACE Unk.	14. MOTHER'S MAIDEN NAME Pauline Walch	BIRTHPLACE Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 487-12-1732	17. INFORMANT'S OWN SIGNATURE Mrs. Perry Ray Wolfe	ADDRESS	

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) CVA — INTERVAL BETWEEN ONSET AND DEATH 1 min

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cerebral atherosclerosis — 5 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 14 Oct, 1968, *to* 29 Dec, 1969, *that I last saw the deceased alive on* 29 Dec, 1969, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Richard Ellis 773 (Degree or title)	23b. ADDRESS Gooding Idaho	23c. DATE SIGNED 6 Jan 70
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE 1-3-69	24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery	24d. LOCATION (City, town, or county) (State) Hagerman Idaho
DATE REC'D BY LOCAL REG. 8-JAN-70 — REGISTRAR'S SIGNATURE Eddie G. Leach	25. EMBALMER Joe B. Leeper Joe B. Leeper	LICENSE NO. E-530

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Leeper Mortuary Wendell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 5 1970 Bureau of Vital Statistics

State File No. 5759
Local Reg. No. 3185
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH 240
a. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
c. LENGTH OF STAY (In this place): 9¾ yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 240
a. STATE: Idaho
b. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
d. STREET ADDRESS (If rural, give location): Magic Valley Manor--North Main

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joe		Alberdi	Dec. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Aug. 18, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheepherder 04	Retired	Bedaronia, Spain	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Candido Alberdi	Spain	Mary Sabala	Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-30-0664	Magic Valley Rest Home	Wendell, Idaho

18. CAUSE OF DEATH 4109
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH * (a) Acute myocardial infarct

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Hrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2-2, 1960, *to* 12-30, 1969, *that I last saw the deceased alive on* 12-29, 1969, *and that death occurred at* 1:20 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Raymond E. Soliel MD	Wendell, Idaho 83355	12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1-3-1970	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
31-DEC-1969	Todd G. Leach	Todd G. Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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2 copies

Certificate of Death
STATE OF IDAHO

State File No. 5760
Local Reg. No. 32
Reg. Dist. No. 242

RECEIVED JAN 9 1970 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Idaho 250	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Lewis 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood c. LENGTH OF STAY (In this place): 2 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Craigmont rural
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093	d. STREET ADDRESS (If rural, give location): 4 mi North

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) Esther	c. (Last) Watson	4. DATE OF DEATH (Month) (Day) (Year) November 18 1969
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: Jan 29 1931	9. AGE (In years last birthday): 38 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 0'	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Grangeville, Idaho	12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME: Alfred Denham	BIRTHPLACE: Lapwai, Idaho	14. MOTHER'S MAIDEN NAME: Gladys Irene Owens	BIRTHPLACE: Kalispell, Montana	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518 32 5743	17. INFORMANT'S OWN SIGNATURE: Eneret E. Watson	ADDRESS: Craigmont, Idaho	

5604

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Intestinal Obstruction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) adhesions with

DUE TO (c) gangrene small bowel 5 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 15, 1969, *to* Nov 18, 1969, *that I last saw the deceased alive on* Nov 18, 1969, *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE 935 Leo J. Rymp, M.D. (Degree or title)	23b. ADDRESS: Cottonwood, Idaho	23c. DATE SIGNED: 12/1/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: November 21 69	24c. NAME OF CEMETERY OR CREMATORY: Lewis Clark Memorial	24d. LOCATION (City, town, or county): Lewiston (State): Idaho
DATE REC'D BY LOCAL REG.: Jan. 2, 1970	REGISTRAR'S SIGNATURE: Elizabeth H. Uhlorn	25. EMBALMER: Clifford Uhlorn	LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5761
Local Reg. No. 74
Reg. Dist. No. 240

BIRTH NO.

RECEIVED DEC 18 1969 Vital Statistics

1. PLACE OF DEATH
a. COUNTY Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Bureau of Hosp. 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kooskia
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Olive b. (Middle) Florence c. (Last) Moke

4. DATE OF DEATH (Month) Dec. (Day) 3 (Year) 1969

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 6, 1884

9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife - Mother

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) New Albany Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Penwell BIRTHPLACE New Albany, Kansas

14. MOTHER'S MAIDEN NAME Catherine Chapman BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 514-09-9699

17. INFORMANT'S OWN SIGNATURE Marjorie Kalica ADDRESS Kooskia, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5770

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Pancreatitis — several days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1963, to 3 Dec, 1969, that I last saw the deceased alive on 3 Dec, 1969, and that death occurred at 10:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE Donald Feltner 487 (Degree or title) M.D.

23b. ADDRESS Grangeville, Idaho

23c. DATE SIGNED 11 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 6 1969

24c. NAME OF CEMETERY OR CREMATORY Pine Grove

24d. LOCATION (City, town, or county) Kooskia (State) Idaho.

DATE REC'D BY LOCAL REG. Dec. 12, 1969

REGISTRAR'S SIGNATURE Irma Cone

25. EMBALMER Robert M Hansen LICENSE NO. E423

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5762
Local Reg. No. 77
Reg. Dist. No. 240

RECEIVED DEC 18 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 250 Idaho
b. CITY OR TOWN Grangeville
LENGTH OF STAY (in this place) 3½ yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho County Nursing Home 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) Idaho County Nursing Home

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARY	ETHEL	CHASE	December 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 3, 1888	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Palouse, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Cochran	Scotland, Indiana	Elizabeth Clark	Lawrence Co. Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 24 9166	Emmett Chase	Grangeville, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	myocardial infarction	unkn
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-21, 1967, *to* 5 Dec, 1969, *that I last saw the deceased alive on* 4 Dec, 1969, *and that death occurred at* 6:45 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Saltman M.D.	Grangeville, Idaho	11 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/9/1969	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15 1969	Irma Cone	Robert R Hansen Robert R Hansen	E 433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

APR 1 1971

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5763
Local Reg. No. 75
Reg. Dist. No. 240

Certificate of Death

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Whitebird Rural
c. LENGTH OF STAY (in this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway # 95 Near Whitebird 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Colorado 06
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Littleton
d. STREET ADDRESS (If rural, give location): 5192 Aberdeen Street

3. NAME OF DECEASED (Type or Print)
a. (First): EARL
b. (Middle): STANLEY
c. (Last): REYNOLDS

4. DATE OF DEATH (Month) (Day) (Year): December 10, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: February 11, 1916
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assistant Manager 26
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): Powers Lake., North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Earl R. Reynolds — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Marie Irving — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 501 30 7066
17. INFORMANT'S OWN SIGNATURE: Mrs Reynolds R.H. — ADDRESS: Littleton, Colorado

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Auto Accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) 13250 (COUNTY) (STATE): North of Riggins Idaho Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 10 69 11 Am
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 4 (Degree or title)
23b. ADDRESS: IDAHO COUNTY CORONER
23c. DATE SIGNED: 12 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Transportation
24b. DATE: 12/12/1969
24c. NAME OF CEMETERY OR CREMATORY: Chapel Hills
24d. LOCATION (City, town, or county) (State): Denver, Colorado

DATE REC'D BY LOCAL REG.: Dec. 13 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen funeral home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 9 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 14 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 3 1970

OCT 3 1973

JUL 25 1979

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

JAN 11 2013

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 24 1969 Bureau of Vital Statistics

State File No. 5764
Local Reg. No. 78
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood,
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) c. (Last) Buettner

4. DATE OF DEATH: (Month) Dec (Day) 11 (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Sept 29 1878

9. AGE (In years last birthday): 91
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Garage owner & Machinist 32

10b. KIND OF BUSINESS OR INDUSTRY: Auto & Implement

11. BIRTHPLACE (State or foreign country): New Holstein, Wisc

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Nicholas Buettner
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Dorothea Wilkens
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 30 8663 A

17. INFORMANT'S OWN SIGNATURE: Roland Buettner ADDRESS: Cottonwood, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 887X Serum Hepatitis — INTERVAL BETWEEN ONSET AND DEATH: 40 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Blood Transfusion — 〃 〃
DUE TO (c): Fractured Hip — 〃 〃

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Generalized arteriosclerosis, senile — cindf.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): XX
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Nursing Home 13
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Grangeville 13 250 Idaho Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 4, 1969 4:15p m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fell in nursing home

22. I hereby certify that I attended the deceased from 12/5, 1969, to 12/11, 1969, that I last saw the deceased alive on 12/10, 1969, and that death occurred at 6:30p m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] 373 (Degree or title): MD
23b. ADDRESS:
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Community
24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: Dec 19 1969
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: [signature]
LICENSE NO.: E 421
FIRM NAME: CLIFFORN FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5765
Local Reg. No. 20
Reg. Dist. No. 242

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Idaho 25D JAN 5 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (In this place): 3 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Mary's Hospital 093

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Idaho 25D
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Greencreek
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Catherine; b. (Middle); c. (Last) Stubbers

4. DATE OF DEATH: (Month) Dec (Day) 17 (Year) 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Aug 16 1870

9. AGE (In years last birthday): 99
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Effingham, Illinois

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Henry Wassmuth
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Mary Ann Hoffmann
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 42 3213 A

17. INFORMANT'S OWN SIGNATURE: Herman Stubbers
ADDRESS: Greencreek, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): ASH disease.
INTERVAL BETWEEN ONSET AND DEATH: Month.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Senility & Generalized arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Abdominal tumor, type undetermined

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept. 19 69 *to* Dec. 17 19 69 *that I last saw the deceased alive on* Dec. 17 19 69 *and that death occurred at* 8:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard E Uhlorn MD
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: 12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 19, 1969
24c. NAME OF CEMETERY OR CREMATORY: Catholic
24d. LOCATION (City, town, or county): Greencreek
(State): Idaho

DATE REC'D BY LOCAL REG.: Dec. 31, 1969
REGISTRAR'S SIGNATURE: Elizabeth N. Uhlorn
25. EMBALMER: Richard Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: UHLORN FUNERAL HOME

JAN 6 1970

APR 10 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5766
Local Reg. No. 79
Reg. Dist. No. 240

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 250
a. COUNTY Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Skookum Buttes area
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Montana 27
b. COUNTY Missoula 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Missoula
d. STREET ADDRESS (If rural, give location) 315 5th. St., East Missoula Route #4

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) H.
c. (Last) Spaulding

4. DATE OF DEATH (Month) (Day) (Year) Dec. 19, 1969

5. SEX Male
6. COLOR OR RACE Cau
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 7, 1914
9. AGE (In years last birthday) 55 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer 17
10b. KIND OF BUSINESS OR INDUSTRY Stillwater Logging
11. BIRTHPLACE (State or foreign country) Co. Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Dana L. Spaulding
BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Nellie May Maier
BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW11 4
16. SOCIAL SECURITY NO. 516-20-3245
17. INFORMANT'S OWN SIGNATURE Genevieve F. Spaulding - Rte #4
ADDRESS Missoula

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fractures - intra-cranial hemorrhage
INTERVAL BETWEEN ONSET AND DEATH few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT X SUICIDE HOMICIDE / (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Forest 09
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13250 Idaho Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12/19/69 10:30 A m.
21e. INJURY OCCURRED WHILE AT WORK [XX] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? Struck by snag while sawing down tree

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 583 + [signature]
23b. ADDRESS [signature]
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE Dec. 23, 1969
24c. NAME OF CEMETERY OR CREMATORY Missoula Cemetery
24d. LOCATION (City, town, or county) (State) Missoula, Montana 59801

DATE REC'D BY LOCAL REG. Dec. 22 1969
REGISTRAR'S SIGNATURE Irma Cone
25. FUNERAL DIRECTOR Squire-Simmons-Carr, ADDRESS 329 E. Pine St., Missoula, Mont. 59801

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JAN 2 1970
JAN 13 1970
JAN 8 - 1970
JAN 16 1970
JAN 24 1997

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5767
Local Reg. No. 1
Reg. Dist. No. 240

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Idaho 250 — JAN 5 1970
b. CITY OR TOWN: Grangeville
c. LENGTH OF STAY IN (this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hosp. 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia
d. STREET ADDRESS (If rural, give location):

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print): a. (First) Edgar — b. (Middle) Curtis — c. (Last) Creal

4. DATE OF DEATH: (Month) Dec. (Day) 23 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 21, 1892

9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Automotive

11. BIRTHPLACE (State or foreign country): Vigo County, Indiana

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Benton Creal — BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Elizabeth Killian — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I 3

16. SOCIAL SECURITY NO.: 529-07-4012

17. INFORMANT'S OWN SIGNATURE: Viola Marion Creal — ADDRESS: Kooskia, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Hr

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic Heart Disease unkn.

DUE TO (c) Cholecystectomy — 2 days

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* acute Cholecystitis, 1 week Duration, Subsiding.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Chronic Cholecystitis with Cholelithiasis,

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 16, 1969, *to* Dec 23 1969, *that I last saw the deceased alive on* Dec 23, 1969, *and that death occurred at* 9:10 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: John Marion MD 373. (Degree or title)

23b. ADDRESS: Grangeville, Id.

23c. DATE SIGNED: 12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 27 1969

24c. NAME OF CEMETERY ~~OR CREMATORY~~: Tahoe

24d. LOCATION (City, town, or county) (State): Kooskia Idaho

DATE REC'D BY LOCAL REG.: Dec. 31 1969

REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: John R Hamer — LICENSE NO.: E 433

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

10173

RECEIVED JAN 9 1970 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5768
Local Reg. No. 21
Reg. Dist. No. 842

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Idaho 250	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Nezperce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood c. LENGTH OF STAY (In this place): 1 day	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First) Peter	b. (Middle) Sylvester	c. (Last) Enneking	4. DATE OF DEATH (Month) (Day) (Year) December 24, 1969
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married	8. DATE OF BIRTH: August 23, 1958	9. AGE (In years last birthday): 11 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student	10b. KIND OF BUSINESS OR INDUSTRY: 03 Gooding State School	11. BIRTHPLACE (State or foreign country): Cottonwood Idaho	12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME: Vincent Enneking	BIRTHPLACE: Keuterville, Idaho	14. MOTHER'S MAIDEN NAME: Evelyn Bensching	BIRTHPLACE: Keuterville, Idaho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT'S OWN SIGNATURE: Sharon Enneking	ADDRESS: Clarkston, Wash.	

8199

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Head Injury, c̄ Concussion of Brain & Brain Hemorrhage.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO (b)~~ /
DUE TO (c) auto accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): / auto accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Keuterville Rd 206	21c. (CITY, TOWN, OR TOWNSHIP) 13250 Keuterville	(COUNTY) (STATE) Idaho, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12-24-69 8A m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? auto accd	

22. *I hereby certify that I attended the deceased from* 8 A M - 12-24 1969, *to* 4:30 Pm 12-24, 1969, *that I last saw the deceased alive on* 12-24-69 at 4:30 Pm *and that death occurred at* 5:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Leo Lynn Lynn (Degree or title) 935	23b. ADDRESS: Cottonwood, Idaho	23c. DATE SIGNED: 12-31-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Dec 27, 1969	24c. NAME OF CEMETERY OR CREMATORY: Keuterville	24d. LOCATION (City, town, or county) (State): Keuterville, Idaho
DATE REC'D BY LOCAL REG.: Jan. 2, 1970	REGISTRAR'S SIGNATURE: Elizabeth H. Uhlorn	25. EMBALMER: Cletus Uhlorn	LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: UHLORN FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5769
Local Reg. No. 3
Reg. Dist. No. 240

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JAN 13 1970

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF (If outside corporate limits, write RURAL and give township): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hosp 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riggins
d. STREET ADDRESS (If rural, give location): Riggins, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): M
c. (Last): STASSART

4. DATE OF DEATH (Month) (Day) (Year): Dec 31, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 30, 1883
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 10
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): New Mexico
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Stassart — BIRTHPLACE: Belgin
14. MOTHER'S MAIDEN NAME: Bertina Harding — BIRTHPLACE: Belgin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 05 1097A
17. INFORMANT'S OWN SIGNATURE: Robert Hansen DPA Records — ADDRESS: Riggins, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
chronic gastro intestinal bleeding of undet. Etiology; Iron-loss anemia, Cholangitis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/30, 1969, *to* 12/31, 1969, *that I last saw the deceased alive on* 12/31, 1969 *and that death occurred at* 9P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 373 M D
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/3/70
24c. NAME OF CEMETERY OR CREMATORY: Riggins
24d. LOCATION (City, town, or county) (State): Riggins, Idaho

DATE REC'D BY LOCAL REG.: Jan. 9 1970
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433
FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 9 1970 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5770
Local Reg. No. 13
Reg. Dist. No. 660

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
c. LENGTH OF STAY (in this place): 6 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 183 W. Short Street ooo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 183 West Short Street

3. NAME OF DECEASED (Type or Print): a. (First) MAYO b. (Middle) McCULLOCH c. (Last)

4. DATE OF DEATH (Month) (Day) (Year): December 24, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 25, 1922

9. AGE (In years last birthday): 47 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Rexburg, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alexander McCulloch — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Ethel Mayo — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII Korea

16. SOCIAL SECURITY NO.: 519-44-6027

17. INFORMANT'S OWN SIGNATURE: Twila McCulloch — ADDRESS: Rigby, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 7 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Asthma — 15 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/4, 1969, *to* 12/24, 1969, *that I last saw the deceased alive on* 10/4, 1969, *and that death occurred at* 10:40 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Alton Hall, M.D. 521

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: Dec. 26, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 27, 1969

24c. NAME OF CEMETERY OR CREMATORY: Pioneer

24d. LOCATION (City, town, or county) (State): Rigby Jefferson Idaho

DATE REC'D BY LOCAL REG.: 12/27/69

REGISTRAR'S SIGNATURE: Mrs. A. B. Eckersell

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 7 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 17 1992

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5771
Local Reg. No. 14
Reg. Dist. No. 640

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jefferson 260 JAN 9 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Roberts
c. LENGTH OF STAY (In this place) Bureau of Statistics yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) X 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Roberts
d. STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print) a. (First) BARNEY b. (Middle) KENDALL c. (Last) LUND

4. DATE OF DEATH (Month) (Day) (Year) Dec. 30, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH Aug. 4, 1911

9. AGE (In years last birthday) 58 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Herder 04

10b. KIND OF BUSINESS OR INDUSTRY Sheep

11. BIRTHPLACE (State or foreign country) Moroni, Utah.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lewis Lund BIRTHPLACE Fountain Green, Ut.

14. MOTHER'S MAIDEN NAME Melissa Bailey BIRTHPLACE Moroni, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 520-09-6193

17. INFORMANT'S OWN SIGNATURE Eddie Lund ADDRESS Moroni, Utah.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 4299
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apparent Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: Inst.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that* XXXX

DUTIES: MAR 4 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5772
Local Reg. No. 1
Reg. Dist. No. 640

BIRTH NO.

RECEIVED JAN 9 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby (rural)
LENGTH OF STAY (in this place): 78
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rte. #1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby (rural)
d. STREET ADDRESS (If rural, give location): Rte. #1

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) STEWART c. (Last) TANNER

4. DATE OF DEATH (Month) (Day) (Year): December 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Nov. 22, 1891	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Sheep & Cattle	Rigby, Idaho.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isaac W. Tanner	So. Cottonwood, Ut.	Emily Hall	Granger, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-16-6581	Ruth W Tanner	Rte. #1 Rigby, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Thrombosis	Sudden
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Coronary Heart Disease	4 years
DUE TO (c)	Arteriosclerotic Heart Disease	years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus.	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	none performed	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 30, 1969, *to* Dec. 30, 1969, *that I last saw the deceased alive on* Dec., 19—, *and that death occurred at* 7:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Asael Tall	M.D.	Rigby, Idaho.	3 Jan. 70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jan. 3, 1970	Little Butte	Annis Jefferson Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 3 1970	Mrs A B Eckersell	Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 25 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 9 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 9 1969 Bureau of Vital Statistics

State File No. 5773
Local Reg. No. 1278
Reg. Dist. No. 440

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY Jerome 270	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Benedict's Hospital 099	d. STREET ADDRESS (If rural, give location) 1437 North Fillmore

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FLORENCE	ALICE	THOMASON	Dec. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	June 29, 1889	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife c/	at home	Westgate, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Corbin	New York	Fannie Winegar	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 44 2077B	X C Thomason	Jerome, Idaho

4274

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute cardiac decompensation + pulmonary edema	12 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Atrial fibrillation with episodes tachycardia	15 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Adenocarcinoma sigmoid colon with obstruction	?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov 26, 1969	Colon (sigmoid) resection and re-anastamosis	Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11/12/69, 19__, *to* 12/1/69, 19__, *that I last saw the deceased alive on* 11/30/69 9PM, 19__, *and that death occurred at* 2:25A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
N. Carlyle Ruail M.D.	Jerome, Idaho	12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 3, 1969	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 8, 1969	Louella M. Deherer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

DEC 26 1978

JUN 12 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5774
Local Reg. No. 1279
Reg. Dist. No. 440

BIRTH NO.

RECEIVED DEC 9 1969 Bureau of Vital Statistics

Informant; Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 211 East Ave. "C" 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 211 East Ave. "C"

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GERTRUDE	LOUISE	BREWER	Dec. 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	June 15, 1877	92		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	at home	Rush Lake, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Horace P. VanKirk	Wisconsin	Margaret Furman	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	527 70 4113	* Mrs Elizabeth B. White	Jerome, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocarditis	2 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	c decompensation	3 das.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Senility	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3-8, 19 69 *to* 12-2, 19 69, *that I last saw the deceased alive on* 11-29-69, 19____, *and that death occurred at* 10:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Reuben C. Matsonsmd	Jerome Ida	12-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec. 6, 1969	Greenwood Mem. Park	Phoenix, Arizona

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 8, 1969	Louella M. Deherer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

JUL 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 1 1 1969
Bureau of Vital Statistics

State File No. 5775
Local Reg. No. 1280
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (In this place): 3-days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell 83355
d. STREET ADDRESS (If rural, give location): Gen. Delivery--city

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): William
c. (Last): O'Donnell

4. DATE OF DEATH (Month) (Day) (Year): Dec. 3, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct. 19, 1906
9. AGE (In years last birthday): 63
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Columbus, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Steven O'Donnell
BIRTHPLACE: Peoria, Illinois
14. MOTHER'S MAIDEN NAME: Mae Moore
BIRTHPLACE: Columbus, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-22-2415
17. INFORMANT'S OWN SIGNATURE: Mrs. Olitha Higginbotham
ADDRESS: Wendell, Ida.

491X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Terminal cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Severe emphysema & bronchitis — 5 yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1966, *to* 3 Dec, 1969, *that I last saw the deceased alive on* 2 Dec, 1969, *and that death occurred at* 2:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 385
23b. ADDRESS: Jerome Ida
23c. DATE SIGNED: 6 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 12-6-1969
24c. NAME OF CEMETERY OR CREMATORY: Wendell Cemetery
24d. LOCATION (City, town, or county) (State): Wendell-Gooding Co., Idaho

DATE REC'D BY LOCAL REG.: Dec. 9, 1969
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: Eddie G. Leach
LICENSE NO.: E-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 12 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5776
Local Reg. No. 1281
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 DEC 15 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome Bureau of Vital Statistics
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 099 D.O.A. St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 412 4th. Ave. East

3. NAME OF DECEASED (Type or Print) a. (First) BERNARD b. (Middle) STEPHEN c. (Last) SCHEER

4. DATE OF DEATH (Month) (Day) (Year) Dec. 9, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH April 15, 1900
9. AGE (In years last birthday) 69 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Morrowville, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Paul Scheer BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Anna Locke BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 42 6837
17. INFORMANT'S OWN SIGNATURE x Richard Scheer ADDRESS Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 19___, *to* ——, 19___, *that I last saw the deceased alive on* ——, 19___, *and that death occurred at* 8:10P *m., from the causes and on the date stated above.*

23a. SIGNATURE R. M. Scheer, 583 4 Ch. J. Coroner (Degree or title)
23b. ADDRESS Jerome
23c. DATE SIGNED 10 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. Dec. 11, 1969
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5777
Local Reg. No. 1282
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 DEC 22 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF (In this place)
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 709 East Main

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) JOSEPH
c. (Last) CARPENTER

4. DATE OF DEATH (Month) (Day) (Year) Dec. 12, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH Jan. 13, 1955
9. AGE (In years last birthday) 14
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY Junior High
11. BIRTHPLACE (State or foreign country) Burley, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Carpenter
BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Barbara Bean
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. -
17. INFORMANT'S OWN SIGNATURE X William M Carpenter
ADDRESS Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

3304

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumonitis — 4 days.
DUE TO (c) Muscular Dystrophy — 15 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 2, 1962 *to* 12/12, 1969, *that I last saw the deceased alive on* 12/12, 1969, *and that death occurred at* 11 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE J. E. Hoax +76 (Degree or title) MD
23b. ADDRESS Jerome, Ida
23c. DATE SIGNED 12/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE Dec. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY Park View Cemetery
24d. LOCATION (City, town, or county) (State) New Plymouth, Idaho

DATE REC'D BY LOCAL REG. Dec. 17, 1969
REGISTRAR'S SIGNATURE Lonella M. Dohrer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5778
Local Reg. No. 1283
Reg. Dist. No. 440

BIRTH NO.

RECEIVED DEC 22 1969 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Jerome 270	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (rural) 83338
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099	d. STREET ADDRESS (If rural, give location): Rt. 3, Box 120

3. NAME OF DECEASED (Type or Print) a. (First) ALVINA	b. (Middle) GLUBRECHT	c. (Last) STUHLBERG	4. DATE OF DEATH (Month) (Day) (Year) Dec. 13, 1969	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Oct. 24, 1885	9. AGE (In years last birthday): 84 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Frankfurt, Germany	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Andreas Glubrecht	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Louise ---	BIRTHPLACE: Germany	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518 28 4323	17. INFORMANT'S OWN SIGNATURE: Bertha Meyers	ADDRESS: Jerome, Ida.	

7969

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Undetermined (sick 6 mo) Many tests were inconclusive.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. ~~DUE TO (b)~~	? Leukemia; hypertension	6 mo. or more
~~DUE TO (c)~~		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Duodenal ulcer; enlarged spleen & liver; terminal abd. distention	

19a. DATE OF OPERATION: 0	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify): 0	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* 12/13/69, 19__, *that I last saw the deceased alive on* 12/12/69, 19__, *and that death occurred at* 7:55 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. Carlyle Small 477 (Degree or title) MD	23b. ADDRESS: Jerome, Idaho	23c. DATE SIGNED: 12/15/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Dec. 16, 1969	24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery	24d. LOCATION (City, town, or county) (State): Jerome, Idaho
DATE REC'D BY LOCAL REG.: Dec. 17 1969	REGISTRAR'S SIGNATURE: Louella M. Deherer	25. EMBALMER: W. L. Hove	LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 9 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5779
Local Reg. No. 1284
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): R.R.#4

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Jerome 83338
d. STREET ADDRESS (If rural, give location): R.R.#4

3. NAME OF DECEASED (Type or Print)
a. (First): NOBLE
b. (Middle):
c. (Last): TURNER

4. DATE OF DEATH (Month) (Day) (Year): December 22, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 3, 1916
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jess Turner — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Birdie Kell — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W.W.#2 4
16. SOCIAL SECURITY NO.: 519-05-7774
17. INFORMANT'S OWN SIGNATURE: Marjorie Turner — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1948, *to* 22 Dec, 1969, *that I last saw the deceased alive on* Sep, 1969, *and that death occurred at* 10:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 385 (Degree or title): M.D.
23b. ADDRESS: Jerome, Idaho
23c. DATE SIGNED: 24 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: 12/24/69
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 24 1969
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5780
Local Reg. No. 1285
Reg. Dist. No. 440

BIRTH NO.

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Benedicts Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural 83338 Jerome
d. STREET ADDRESS (If rural, give location): Route # 2 2 mi. W. 1½ So.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROBERT	CLIFFORD	BOYD	Dec. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 13, 1909	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer of	Farming	Aurora, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert F. Boyd	Penn.	Mary Torgerson	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-10-1171	Robert L Boyd	Heyburn, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-23 , 1969 , *to* 12-23- , 1969 , *that I last saw the deceased alive on* 12-23- , 1969 , *and that death occurred at* 11:30 PM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. M. Heber, Lic. #385	Jerome, Idaho	29 Dec 69.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec. 27, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 31, 1969	Lowella M. Deburin	Edgar J. Robertson	E-507

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 5 1970
OCT 2 7 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
BIRTH NO. JAN 9 1970 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5781
Local Reg. No. 1287
Reg. Dist. No. 440

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 298 Madison Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	KENNETH	STANGER	Dec. 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan. 10, 1931	38		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction Worker	Highway Construction	Jerome, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lawrence Stanger	Utah	Nellie Hogge	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean War 6	518-24-5832	X Mrs Shirley Mae Stanger	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

"This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) acute myocardial infarct. 2 hrs — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-29-69, 19__, *to* 12-29-, 1969, *that I last saw the deceased alive on* 12-29, 1969, *and that death occurred at* 4:05P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
457 Lawrence E. Schaer MD	Wendell, Idaho	1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jan. 2, 1970	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 8, 1970	Louella M. Scherer	W. L. Hove	E431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 13 1970
MAR 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

BIRTH NO. JAN 9 1970

Certificate of Death
STATE OF IDAHO

State File No. 5782
Local Reg. No. 1286
Reg. Dist. No. 440

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Jerome 270	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Lewis 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338 c. LENGTH OF STAY (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Genesee 83832
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Long Term & Extended Care Unit 357	d. STREET ADDRESS (If rural, give location) No Record

3. NAME OF DECEASED (Type or Print)	a. (First) DOROTHY	b. (Middle) ANGELA	c. (Last) POND	4. DATE OF DEATH (Month) (Day) (Year) December 31, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 20, 1892	9. AGE (In years last birthday) 77 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No Record 00	10b. KIND OF BUSINESS OR INDUSTRY No Record	11. BIRTHPLACE (State or foreign country) Pomeroy, Washington	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy Driscoll, BIRTHPLACE No Record		14. MOTHER'S MAIDEN NAME Caroline Vivian Fulford, BIRTHPLACE No Record		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. no record	17. INFORMANT'S OWN SIGNATURE Hospital records, St. Benedicts Hosp. and Nursing Home, Jerome, Idaho	ADDRESS	

4339

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) *This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Basilar Artery Thrombosis	INTERVAL BETWEEN ONSET AND DEATH 48 hr
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis	5 yrs
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September, 1962, *to* Dec 31, 1969, *that I last saw the deceased alive on* Dec 31, 1969, *and that death occurred at* 6:33 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 385 (Degree or title)	23b. ADDRESS Box 68 Shoshone Idaho	23c. DATE SIGNED 1-6-70	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3	24b. DATE Jan. 3, 1970	24c. NAME OF CEMETERY OR CREMATORY Genesee Cemetery	24d. LOCATION (City, town, or county) (State) Genesee, Idaho
DATE REC'D BY LOCAL REG. Jan. 8, 1970	REGISTRAR'S SIGNATURE Louella M. Scherer	25. EMBALMER W. L. Hove	LICENSE NO. E431

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

SEP 2 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 9 1969 Bureau of Vital Statistics

State File No. 5783
Local Reg. No. 351
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
LENGTH OF STAY (In this place):
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Ironwood Clinic

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 835 W. Garden Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	H.	McCormick	Dec. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 26, 1905	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bus Driver 10	Greyhound	Lincoln County, Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George	Ireland	Katherine O'Gallaher	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	517-03-9164	M. Helen McCormick	Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) ASHD.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec. 1962, 19__, to present, 19__, *that I last saw the deceased alive on* Dec 1, 1969, *and that death occurred at* 11:45 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 128	MD	920 Ironwood Dr. Coeur d'Alene, Idaho	12-2-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Dec. 4, 1969	Grandview Cemetery	Bonners Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	EMBALMER	LICENSE NO.
Dec. 4, 1969	Lorraine K. Brush	M. K. Eplinger Jr.	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 9 1969

AUG 2 6 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

BIRTH NO. DEC 1 6 1969

Certificate of Death
STATE OF IDAHO

State File No. 5784
Local Reg. No. 355
Reg. Dist. No. 120

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene 28
d. STREET ADDRESS (If rural, give location): 606 1/2 Indiana Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	W.	Jones	Dec. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 12,1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Custodian 04	Elks Club	Aberdeen, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unob. Jone	Unob.	Unob.	Unob.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	533-10-4709A	Mrs. Ann Jones (D.E.)	Coeur d' Alene, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5741

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Uremia	24 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Septic shock	72 hours
DUE TO (c)	Cholecystitis, cholelithiasis and cholangitis	10 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* November 30, 1969, *to* December 4, 1969, *that I last saw the deceased alive on* December 4, 1969, *and that death occurred at* 2:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X H. Don Moseley, M.D. 375	421 Coeur d'Alene Avenue	12/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-8-69	Restlawn Memorial Park	Coeur d' Alene

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 10, 1969	Lorraine K. Brush	Bill Duff	E-439

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5785
Local Reg. No. 354
Reg. Dist. No. 120

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeurd' Alene
d. STREET ADDRESS (If rural, give location): 2002 Front Street.

3. NAME OF DECEASED (Type or Print): a. (First) LESTER b. (Middle) C. c. (Last) GARRETT

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 5, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 4/12/1882

9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: UNKNOWN
BIRTHPLACE: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN
BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-05-0845A

17. INFORMANT'S OWN SIGNATURE: Emma Garrett
ADDRESS: 2002 Front St. Cd'A, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4109 Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-30, 1969, *to* 12-5, 1969, *that I last saw the deceased alive on* 12-5, 1969, *and that death occurred at* 4:05 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE: William M. Lanham 622 (Degree or title) MD

23b. ADDRESS

23c. DATE SIGNED: 12-8-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/9/69

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Dec 9, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

MAY 29 1986

JUN 13 1996

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5786
Local Reg. No. 333
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 5 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cd'A Homes Nur. Home 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) ETHEL b. (Middle) L. c. (Last) CAMERON

4. DATE OF DEATH (Month) (Day) (Year) Dec. 6, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 9/19/1898

9. AGE (In years last birthday) 71
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY OWN HOME

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joweph McFeron BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Margaret Mc Muken BIRTHPLACE Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-05-2513

17. INFORMANT'S OWN SIGNATURE Francis Cameron ADDRESS Post Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4379

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Vomiting — 2 hours

DUE TO (c) Cerebral Arteriosclerosis — 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 17, 1969, *to* Dec 6, 1969, *that I last saw the deceased alive on* Dec 2, 1969, *and that death occurred at* 4:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 530 M.D.

23b. ADDRESS 920 Ironwood Dr. Coeur d Alene Idaho

23c. DATE SIGNED Dec 8, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/10/69

24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery

24d. LOCATION (City, town, or county) (State) Post Falls, Idaho

DATE REC'D BY LOCAL REG. Dec. 15, 1969

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred Noland LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5787
Local Reg. No. 370
Reg. Dist. No. 120

Certificate of Death

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 281
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 20 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3115 Government Way 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 3115 Government Way

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) E.
c. (Last) PAUL

4. DATE OF DEATH (Month) (Day) (Year) Dec. 6, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 2/17/1887
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Huntington, Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John E. Paul — BIRTHPLACE UNKNOWN
14. MOTHER'S MAIDEN NAME Julia Hogan — BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO. 565-12-5569
17. INFORMANT'S OWN SIGNATURE — ADDRESS William B. Paul Las Vegas, Nev.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

890X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Conflagration – Trailer House — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Possibly – Emphysema and
DUE TO (c) Chronic myocarditis — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — Years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) accident.
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 281 (COUNTY) (STATE) Coeur d'alene Kootenai Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Trailer House Fire Burned clothes.

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 583 4 (Degree or title) Coroner
23b. ADDRESS Coeur d'alene Idaho
23c. DATE SIGNED 12-17-'69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/12/69
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Dec 29, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred Noland — LICENSE NO. E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 26 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 30 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 2 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5788
Local Reg. No. 352
Reg. Dist. No. 120

RECEIVED DEC 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai (28)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place): 9 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital (10)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai (28)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Post Falls
d. STREET ADDRESS (If rural, give location): Route #2 Box 130

3. NAME OF DECEASED (Type or Print): a. (First) ROYCE b. (Middle) L. c. (Last) BEACH

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	4/30/02	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ball Mill Operator (07)
10b. KIND OF BUSINESS OR INDUSTRY: Pare Mine
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Orin Beach — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Fanny Grant — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 121-18-3429
17. INFORMANT'S SIGNATURE: Verna Beach — ADDRESS: Route #2 Box 130 Post Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5192 Cor Pulmonale

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Lung Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. A5+10

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 9, 1963, *to* present, 19___, *that I last saw the deceased alive on* 12-7-69, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) (28)
23b. ADDRESS: 920 Ironwood Dr. Coeur d'Alene, Idaho
23c. DATE SIGNED: 12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/11/69
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Park
24d. LOCATION (City, town, or county) (State): Coeur D' Alene, Idaho

DATE REC'D BY LOCAL REG.: Dec. 15, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred Noland — LICENSE NO.: E-493
FIRM NAME: ~~Yates Funeral Home~~

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 19 1969

JAN 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5789
Local Reg. No. 35-7
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): —
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 101 Coeur d'Alene Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Luke; b. (Middle) V.; c. (Last) McCabe

4. DATE OF DEATH (Month) (Day) (Year): Dec. 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Oct. 20, 1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unobtainable — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 519-18-9571
17. INFORMANT'S OWN SIGNATURE: Frances V. McCabe — ADDRESS: Coeur d'Alene

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4124

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial insufficiency — 2 years
DUE TO (c) Anteriosclerotic cardiovascular disease — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — 2 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 17, 1969, *to* December 7 1969, *that I last saw the deceased alive on* December 6 1969, *and that death occurred at* 5:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Don Moseley M.D.	375	421 Coeur d'Alene Ave.	12/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec. 10, 1969	Holy Cross Cemetery	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 12, 1969	Lorraine K. Brush	Bill Huff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 5 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5790
Local Reg. No. 359
Reg. Dist. No. 120

Certificate of Death

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1601 Front St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 1601 Front St.

3. NAME OF DECEASED (Type or Print)
a. (First): Filmore
b. (Middle): A.
c. (Last): Peterson

4. DATE OF DEATH (Month) (Day) (Year): December 7, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 27,1917
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert C. Peterson — BIRTHPLACE: Mich
14. MOTHER'S MAIDEN NAME: Mildred Dillon — BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 518-05-2615
17. INFORMANT'S OWN SIGNATURE: Mrs. Mamie Peterson (DE) — ADDRESS: Cd'a, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion, Acute, severe

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fatal
DUE TO (c): Hypotension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Minutes / Chronic

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967, 19__, *to* 12/7/69, 19__, *that I last saw the deceased alive on* 11/17/69, 19__, *and that death occurred at* 6:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lynn C. Fredrikson MD. 177
23b. ADDRESS: Coeur d' Alene, Idaho.
23c. DATE SIGNED: 12/9/69.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec.10,1969
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.: Dec 10, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5791
Local Reg. No. 356
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cœur d' Alene
LENGTH OF STAY (in this place): Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Mem. Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 510 Wallace Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MILO	G.	KING	Dec. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	9/30/1890	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper 19	Potlatch Merc	Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph King	England	Sarah UNKNOWN	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-4882	Helma King	510 Wallace Cd'A, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia, Acute, Post Operative	One Day.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Post operative left colon resection for	
DUE TO (c)	Adenocarcinoma.	Eight Days.
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Hypertension, Obesity, Parkinsons Disease	Chronic

1538

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Left colon adenocarcinoma obstructive.	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1967, 19___, *to* 12/9/69, 19___, *that I last saw the deceased alive on* 12/8/69, 19___, *and that death occurred at* 2:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Lynn C. Dickinson MD	Coeur d Alene, Idaho.	12/10/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	12/12/69		

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15, 1969	Lorraine K. Brush	Frank Houde	E-521

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5792
Local Reg. No. 368
Reg. Dist. No. 120

BIRTH NO. 69-12598

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hopsital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): Rt. #4 Box 116

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Infant	Girl	Miller	December 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Feamle	White	Never Married	Dec. 9,1969			2 /

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none 62	none	Coeur d' Alene, Ida.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Donald P. Miller	South Dakota	Stella O. Fuhrman	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	none	Donald Miller	Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

7762

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Respiratory distress syndrome — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9 Dec, 1969, *to* 9 Dec, 19 69, *that I last saw the deceased alive on* , 19 , *and that death occurred at* 5:53 am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
08 C. L. Culbertson, M.D.	Hayden Lake, Idaho	Dec.26,69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec.11,1969	St. Thomas Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 29,1969	Lorraine K. Brush	M. F. Ruplinger Jr.	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5793
Local Reg. No. 363
Reg. Dist. No. 120

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 281
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kingston
d. STREET ADDRESS (If rural, give location) Box 125

3. NAME OF DECEASED (Type or Print)
a. (First) Leona
b. (Middle) J.
c. (Last) Erickson

4. DATE OF DEATH (Month) (Day) (Year) December 10, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 9, 1917
9. AGE (In years last birthday) 52 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Millicent, Alberta
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Spahn — BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Florence Bell Hill — BIRTHPLACE Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-26-8272
17. INFORMANT'S OWN SIGNATURE Alfred C. Erickson Jr. — ADDRESS Enaville

492X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Respiratory Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 6 weeks heavy Menorrhagia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION Dec 10 1969
19b. MAJOR FINDINGS OF OPERATION Moderate endometrial tissue
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 22, 1968, *to* Dec 10, 1969, *that I last saw the deceased alive on* Dec 10, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE C. E. Thompson MD (Degree or title)
23b. ADDRESS 920 Ironwood Coeur d Alene Idaho
23c. DATE SIGNED 12-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Dec 16, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Piplinger Jr.
LICENSE NO. E-397
FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5794
Local Reg. No. 361
Reg. Dist. No. 120

RECEIVED DEC 16 1969 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 280 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 Miles E. on Highwy #10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27
b. COUNTY: Missoula 035
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Missoula
d. STREET ADDRESS (If rural, give location): 2333 South Seventh, West

3. NAME OF DECEASED (Type or Print)
a. (First): Larry
b. (Middle): E.
c. (Last): Taylor

4. DATE OF DEATH (Month) (Day) (Year): December 11, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: June 1, 1938

9. AGE (In years last birthday): 31
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): District Manager

10b. KIND OF BUSINESS OR INDUSTRY: 26 Kaiser JeepCorp.

11. BIRTHPLACE (State or foreign country): Great Falls, Montana

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawrence E. Taylor Sr.
BIRTHPLACE: Montana

14. MOTHER'S MAIDEN NAME: Margaret R. Cummings
BIRTHPLACE: North Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 517-38-7231

17. INFORMANT'S OWN SIGNATURE: Lawrence Taylor
ADDRESS: Missoula, Mont.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): accidental traumatism due to — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): automobile accident — Immediate
DUE TO (c): Skull Fracture — "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) 13,280 IME. Coeur d'Alene **(COUNTY)** Kootenai **(STATE)** Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 11, 1969 a m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Truck rolled down on icy highway

22. *I hereby certify that I attended the deceased from* Did not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood M.D. 583 (Degree or title) Coroner

23b. ADDRESS: Coeur d' alene Idaho

23c. DATE SIGNED: 12-11-'69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Dec. 11, 1969

24c. NAME OF CEMETERY OR CREMATORY: Banks Funeral Home

24d. LOCATION (City, town, or county) (State): Choteau, Montana

DATE REC'D BY LOCAL REG.: Dec. 12, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: T. K. Tipling Jr.

LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 26 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 10 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5795
Local Reg. No. 373
Reg. Dist. No. 120

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Kootenai 28/
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 3403 N. 15th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Effie
b. (Middle): Marie
c. (Last): Young

4. DATE OF DEATH (Month) (Day) (Year): December 11, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 12, 1887

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Harrod, Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elias P. Irwin
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Nancy Lee Mauk
BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 563-30-1972

17. INFORMANT'S OWN SIGNATURE: X Mrs R. G. Scholtz
ADDRESS: Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 2509 Cerebro vasc. accident
INTERVAL BETWEEN ONSET AND DEATH: 2 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): gen art. sclerosis,
DUE TO (c): diabetes mellitus.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-23, 1968, *to* 12-11, 1969, *that I last saw the deceased alive on* 12-11, 1969, *and that death occurred at* 1:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 025 Brad Barclay MD
23b. ADDRESS: Coeur d'Alene Ida
23c. DATE SIGNED: Dec.17,69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-15,1969
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene Idaho

DATE REC'D BY LOCAL REG.: Dec 23, 1969
REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: M. F. Englinger
LICENSE NO.: E-397
FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5796
Local Reg. No. 365
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cœur d' Alene
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace Nur. Home 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 1614 Coeur d' Alene Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ELLA	A.	LAABS	Dec.	12,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	3/26/1884	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleswoman 24
10b. KIND OF BUSINESS OR INDUSTRY: Avon Co.
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Hep — BIRTHPLACE: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN — BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-30-4670
17. INFORMANT'S SIGNATURE: Don Laabs — ADDRESS: Coeur d' Alene, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1748

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis to Brain. — 3 weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. , 19 69, to 12 - 12 , 19 69, *that I last saw the deceased alive on* 12 - 11 , 19 69, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, 572 M.D.	Coeur d'alene Idaho	12-17-'69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/16/69	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 17, 1969	Lorraine K. Brush	Frank Houde	E-521

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5797
Local Reg. No. 362
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 281 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Coeur d'Alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 201 Forest Drive

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) G.
c. (Last) Bradley

4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 18, 1891
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Thomas Bradley — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Josephine Koffer — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) Ida. Natl. Guard
16. SOCIAL SECURITY NO. 519-20-2067
17. INFORMANT'S OWN SIGNATURE M. May Bradley — ADDRESS Coeur d'Alene

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic myocarditis — Years
DUE TO (c) arteriosclerosis — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1960, to 12-14, 1969, that I last saw the deceased alive on 12-14, 1969, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 572 (Degree or title)
23b. ADDRESS Coeur d'alene, Idaho
23c. DATE SIGNED 12-15-'69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. Dec. 16, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 26 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 17 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5798
Local Reg. No. 364
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 1011 N. 2nd Street

3. NAME OF DECEASED (Type or Print)
a. (First) Hubert
b. (Middle) J.
c. (Last) Koep

4. DATE OF DEATH (Month) (Day) (Year) Dec. 15, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Mar. 12,1889
9. AGE (In years last birthday) 80
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairyman-Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Koep
BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Margaret Kauth
BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-26-6712
17. INFORMANT'S OWN SIGNATURE Kay J Koep
ADDRESS Coeur d'Alene, Idaho

402X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 11
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Prostate — 1 year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 60, *to* 12-15, 19 69, *that I last saw the deceased alive on* 12-14, 19 69, *and that death occurred at* 5:21 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 572 (Degree or title)
23b. ADDRESS Coeur d'alene Idaho
23c. DATE SIGNED 12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec.17,1969
24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. Dec 16, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: English Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 24 1969

JUN 25 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

JAN 2 1970

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5799
Local Reg. No. 372
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 281 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 261 Pinewood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) Rt. #2 Box 188

3. NAME OF DECEASED (Type or Print) a. (First) Richard b. (Middle) c. (Last) Sharples
4. DATE OF DEATH (Month) (Day) (Year) Dec. 15, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 28, 1896
9. AGE (In years last birthday) 72 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance 08
10b. KIND OF BUSINESS OR INDUSTRY State Highway
11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME James Sharples BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Mary Hamilton BIRTHPLACE Unbtainable
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-05-5612
17. INFORMANT'S OWN SIGNATURE X Richard Sharples Jr. ADDRESS Rt #2 Box 188

1597

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Stomach & Esophagus — INTERVAL BETWEEN ONSET AND DEATH 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Dehydration — 2 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/14, 1960, *to* 12/15, 1969, *that I last saw the deceased alive on* 12/15, 1969, *and that death occurred at* 4:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE Ted Stevenson (225) (Degree or title) M.D.
23b. ADDRESS Coeur d'Alene Idaho
23c. DATE SIGNED 12/17/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 17, 1969
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. Dec 23, 1969
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER M. R. Tiplinger Jr.
LICENSE NO. E-397
FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5800
Local Reg. No. 366
Reg. Dist. No. 120

BIRTH NO.

RECEIVED

DEC 23 1969

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Route 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 553
a. STATE California 05 b. COUNTY Los Angeles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey
d. STREET ADDRESS (If rural, give location) 13403 Earnshaw

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Kenneth	Gayland	Whisler	December 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	Nov. 27, 1913	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction 11	Heavy Machine	Okla.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ralph V. Whisler	Okla	Maude M. Adamson	Okla.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	522-10-0831	Mrs Joyce Oliver	Post Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable myocardial infarct acute — INTERVAL BETWEEN ONSET AND DEATH: abrupt

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 2 prior myocardial infarcts
DUE TO (c) Hospital stay Dec. 1969 for

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Re infarction syndrome

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1968, 19___, to 12-16, 1969, that I last saw the deceased alive on 12-9, 1969, and that death occurred at ___ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Howard A Hughes MD	Coeur D'Alene Idaho	12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 19, 69	Pine Grove Cemetery	Rathdrum Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 16, 1969	Lorraine K. Brush	M. F. Pfplinger Jr.	E-397

FIRM NAME English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 2 4 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5801
Local Reg. No. 278
Reg. Dist. No. 120

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 | JAN 13 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
LENGTH OF STAY (in this place): 15 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 503 2nd. St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
INGA	C.	THOMPSON	Dec. 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	5/16/1882	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Bjunn, Norway	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Roy Thompson	Coeur d'Alene, Ida.

4124

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia	24 hours
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cardiac Decompensation	3 years
DUE TO (c)	Arteriosclerotic cardiovascular disease	20 years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Cerebral ischemia & diabetes mellitus	3 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 30, 19 66, *to* Dec. 19, 19 69, *that I last saw the deceased alive on* Dec. 11, 19 69, *and that death occurred at* 4:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Don Moseley M.D.	421 Cd'A Ave., Coeur d'Alene, Id.	12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/22/1969	Pinegrove Cemetery	Rathdrum, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 5, 1970	Lorraine K Brush	Fred H. Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5802
Local Reg. No. 3991
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 13 1970 Bureau of Vital Statistics

Thompson

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF RESIDENCE (In this place): 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 619 Ichabod

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 619 Ichabod

3. NAME OF DECEASED (Type or Print): a. (First) PATRICK; b. (Middle) F.; c. (Last) WILLIAMS

4. DATE OF DEATH: (Month) Dec. (Day) 19, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 6/1/1924

9. AGE (In years last birthday): 45

IF UNDER 1 YR. Months / Days

IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman

10b. KIND OF BUSINESS OR INDUSTRY: City Police

11. BIRTHPLACE (State or foreign country): Cook, Minn

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Williams
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Elizaveth Gavan
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 474-16-9361

17. INFORMANT'S OWN SIGNATURE: LaVonne Williams
ADDRESS: Cd'A, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): ASHD with — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Myocardial Infarction — 15 minutes
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/3, 1964, *to* 12/10, 1969, *that I last saw the deceased alive on* 12/10, 1969, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: C E Thompson 530 (Degree or title) MD

23b. ADDRESS: 920 Ironwood Dr. Coeur d Alene Idaho

23c. DATE SIGNED: 12-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/22/1969

24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

24d. LOCATION (City, town, or county) (State): Post Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 5, 1970

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred H. Noland

LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5803
Local Reg. No. 367
Reg. Dist. No. 120

BIRTH NO.

JAN 2 1970

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Kootenai 281	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene c. LENGTH OF [illegible] place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hopsital 101	d. STREET ADDRESS (If rural, give location) 511 Coeur d' Alene Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) Bernice	b. (Middle)	c. (Last) DeSmithers	4. DATE OF DEATH (Month) (Day) (Year) December 21, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH June 12, 1912	9. AGE (In years last birthday) 57 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress 06	10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Spokane, Wn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Sherburne	BIRTHPLACE Wisconsin	14. MOTHER'S MAIDEN NAME Edith Harlow	BIRTHPLACE Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 518-24-1626	17. INFORMANT'S OWN SIGNATURE Edith Sherburne	ADDRESS Coeur d'Alene	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

5710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Laennec's Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Dec 4 1969	19b. MAJOR FINDINGS OF OPERATION Laennec's Cirrhosis of Liver with Ascites	20. AUTOPSY? Yes ☒ No ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify) —	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Nov 10, 1969, *to* Dec 21, 1969, *that I last saw the deceased alive on* Dec 21, 1969, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 313 (Degree or title)	23b. ADDRESS 411 Coeur d'Alene, Idaho	23c. DATE SIGNED 12.23.69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 24,69	24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho
DATE REC'D BY LOCAL REG. Dec 29, 1969	REGISTRAR'S SIGNATURE Lorraine K. Brush	25. EMBALMER Bill Duff	LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5804
Local Reg. No. 376
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 13 1970 Bureau of Vital Statistics

DAUGHERTY

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alen
c. LENGTH OF STAY (In this place) 8 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Coeur d'Alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene,
d. STREET ADDRESS (If rural, give location) Coeur d'Alene Homes

3. NAME OF DECEASED (Type or Print)
a. (First) ALVILDE
b. (Middle)
c. (Last) SOLSVIK

4. DATE OF DEATH (Month) (Day) (Year) Dec. 22, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 8/4/1891

9. AGE (In years last birthday) 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Spokane, Washington

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alous Krone
BIRTHPLACE Norway

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-34-1368

17. INFORMANT'S OWN SIGNATURE Roy Solsnik - Coeur d'Alene, Ida.
ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) A.S.H.D. & C.F. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1965, 19____, *to* present, 19____, *that I last saw the deceased alive on* 12-19-69, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS 920 Ironwood Dr. Coeur d'Alene, Idaho

23c. DATE SIGNED 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 24, 69

24c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Pk.

24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. Jan 5, 1970

REGISTRAR'S SIGNATURE Lorraine K Brush

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5805
Local Reg. No. 377
Reg. Dist. No. 120

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO. WOOD

JAN 13 1970

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Koorenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 308 W.15th. (Home) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) 308 W. 15th.

3. NAME OF DECEASED (Type or Print)
a. (First) Alonzo
b. (Middle) E.
c. (Last) Springer

4. DATE OF DEATH (Month) (Day) (Year) Dec. 23, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 9/22/1891
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician 2'
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Paulding, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W.W. I 3
16. SOCIAL SECURITY NO. 317-10-6520
17. INFORMANT'S OWN SIGNATURE Jennie Springer — ADDRESS Post Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes mellitus — Years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. (Degree or title) 583 + Coron
23b. ADDRESS Coeur d'Alene, Idaho
23c. DATE SIGNED 12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 12/25/1969
24c. NAME OF CEMETERY OR CREMATORY Covington Memorial
24d. LOCATION (City, town, or county) (State) Fort Wayne, Ind.

DATE REC'D BY LOCAL REG. Jan. 7, 1970
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred H. Noland
LICENSE NO. E-493

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 15 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 11 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 12 1970

FEB 13 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5806
Local Reg. No. 371
Reg. Dist. No. 120

BIRTH NO.

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Kootenai — JAN 2 1970

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene

c. LENGTH OF STAY (In this place): Bureau of Vital Statistics

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Nettleton Gulch Road

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho — b. COUNTY: Kootenai

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene

d. STREET ADDRESS (If rural, give location): Nettleton Gulch Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joseph	Ewin	Rivers	December 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 4, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bus Driver 08	School Dist. 271	Maine	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unobtainable	Unobtainable	Unobtainable	Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	128-09-4575	x Ron d. Ewin	Springfield, Oreg

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

795X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Natural causes exact nature

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): unknown. Death sudden

DUE TO (c): and abrupt. No evidence

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: of external causes

INTERVAL BETWEEN ONSET AND DEATH: abrupt

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* no care., 19 seen after death, 19, *that I last saw the deceased alive on* 19, *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M Hughes MD

23b. ADDRESS: Coeur D'Alene Idaho

23c. DATE SIGNED: 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 30, 69	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Lorraine K. Brush	M. F. Bushinger Jr.	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

FEB 25 1970

MAR 3 1970

APR 3 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 15 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 07 1990

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5807
Local Reg. No. 369
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: 281 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (If this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 103 Coeur d'Alene Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 715 Smylie Ave

3. NAME OF DECEASED (Type or Print): a. (First) Annabelle; b. (Middle); c. (Last) Murphy

4. DATE OF DEATH (Month) (Day) (Year): Dec. 25, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 16, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Montana

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Moore
BIRTHPLACE: Montana

14. MOTHER'S MAIDEN NAME: Nelson
BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 518-03-6542

17. INFORMANT'S OWN SIGNATURE: Lee Bates
ADDRESS: Post Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 9 years

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary artery disease — 4 years
DUE TO (c): Generalized arteriosclerosis — 4 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Carcinoma cervix - treated — 4 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1961, *to* Dec 25, 1969, *that I last saw the deceased alive on* Dec 24, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Wray Wilson MD

23b. ADDRESS: Coeur d'Alene, Idaho

23c. DATE SIGNED: 12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 29, 1969

24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

24d. LOCATION (City, town, or county) (State): Post Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 29, 1969

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: M. F. Ryplinger Jr.

LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 9 1970

DEC 2 0 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 5808
Local Reg. No. 374
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280 JAN 13 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Spirit Lake 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Washington 48 b. COUNTY Sppkane 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elk
d. STREET ADDRESS (If rural, give location) Box 141A - Rt. #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Pearl	Lorene	JACKSON	December 29, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	9/19/1914	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife of	At Home	Reardan, Wash.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Nester Smelcer	UNKNOWN	Pearl McDowell	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	UNKNOWN	Lawrence J. Jackson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 954X Suicide by Drowning. — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ~~ACCIDENT~~ SUICIDE ~~HOMICIDE~~ (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) / 3280 (COUNTY)	(STATE)
Suicide	Lake. 18	Spirit Lake	Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
12-29-'69 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	apparently jumped into Lake.

22. *I hereby certify that I attended the deceased from* Did not. , 19____, to ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 583 Coroner	Coeur d'alene Idaho	1-6-'70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	1/5/70	Hazen Jea Funeral Home	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 7, 1970	Lorraine K. Brush	Frank Ho ude	E-521

Federal Security Agency
United States Public Health Service FORM DH–63021

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5809
Local Reg. No. 375
Reg. Dist. No. 120

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 JAN 13 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 2514. N. 7th St.

3. NAME OF DECEASED (Type or Print): a. (First) Adolph; b. (Middle); c. (Last) Meilke

4. DATE OF DEATH (Month) (Day) (Year): December 31, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: March 25,1881

9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unobtainable 08

10b. KIND OF BUSINESS OR INDUSTRY: Forest Service

11. BIRTHPLACE (State or foreign country): Ontario, Canada

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl Meilke — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Henretta Schmoekle — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO. 519-16-2693T

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Pembroke, Ontario

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Pulmonary Congestion — 1 week
Senility

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/17, 1969, *to* 12/31, 1969, *that I last saw the deceased alive on* 12/31, 1969, *and that death occurred at* 2:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE 225 Ruth Lemon M.D. (Degree or title)
23b. ADDRESS Coeur d'Alene Idaho
23c. DATE SIGNED 1/5/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jan. 5,1970
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Park
24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: Jan 6,1970
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bell Mortuary
LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5810
Local Reg. No. 141
Reg. Dist. No. 200

BIRTH NO.

RECEIVED DEC 16 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN Moscow | LENGTH OF STAY (in this place) 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho | b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Guy		Soderstrom	Dec. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Aug. 10, 1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Woodsman 17		Rutland, North Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred Soderstrom	Sweden	Anna Lindberg	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	Yes	x Ida Johnson	Troy, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Strangulation of Inguinal Hernia — INTERVAL BETWEEN ONSET AND DEATH 24 hours approximately

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Myocardial Infarction — 1960

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ~~Dec~~ 1953, *to* 12-5, 1969, *that I last saw the deceased alive on* 12-5, 1969, *and that death occurred at* 8:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Omer H Drury MD	Troy Idaho	12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 8, 1969	Dry Creek Cemetery	near Troy, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/10/69	Wayne R Heckard	E. Pete Albertson	E-525

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

DUTIES:

DEC 1 8 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5811
Local Reg. No. 143
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Troy
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Andrew
b. (Middle): Jackson
c. (Last): Frary

4. DATE OF DEATH (Month) (Day) (Year): Dec 7 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: January 18, 1906
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sandcoulee, Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Frary — BIRTHPLACE: N.D.
14. MOTHER'S MAIDEN NAME: Frances Vaughn — BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW2 H
16. SOCIAL SECURITY NO.: 712-09-2009
17. INFORMANT'S OWN SIGNATURE: x L.C. Tubb — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of prostate — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1967, *to* Dec, 1969, *that I last saw the deceased alive on* Dec 5, 1969, *and that death occurred at* 10 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE: Lodger Hawkins MD 791 (Degree or title)
23b. ADDRESS: 2B N Main Moscow Idaho
23c. DATE SIGNED: 12-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 11, 1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county): Moscow (State): Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: Donald Ward — LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 5 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 31 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5812
Local Reg. No. 144
Reg. Dist. No. 200

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 241
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (In this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 2 Box 293

3. NAME OF DECEASED (Type or Print): a. (First) Elizabeth; b. (Middle); c. (Last) Heick

4. DATE OF DEATH: (Month) Dec (Day) 7 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: January 14, 1895

9. AGE (In years last birthday): 74 | If under 1 year: Months / Days | If under 1 hr.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Arlington, Minn.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Karl Lettenmaier — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Bertina Ollig — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-42-0141

17. INFORMANT'S OWN SIGNATURE: Leonard Heick — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1820

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma Endometrium uterus — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-2-69

19b. MAJOR FINDINGS OF OPERATION: Carcinoma Endometrium Metastatic to Urethra

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-1-67, *to* 12-2-69, *that I last saw the deceased alive on* 12-2-69, *and that death occurred at* 1 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Laverd C Valder 541 (Degree or title): MD

23b. ADDRESS: Moscow Idaho

23c. DATE SIGNED: 12-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec 9, 1969

24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery

24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1969

REGISTRAR'S SIGNATURE: Maynard Heiskari

25. EMBALMER: Donald Ward — LICENSE NO.: E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 30 1969
JAN 9 1970
MAY 14 1970
JUN 29 1971
MAR 29 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5813
Local Reg. No. 146
Reg. Dist. No. 200

RECEIVED DEC 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 720 E. D St.

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Fred c. (Last) Schnell

4. DATE OF DEATH: (Month) Dec (Day) 10 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: June 3, 1893

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): implement dealer

10b. KIND OF BUSINESS OR INDUSTRY: machinery

11. BIRTHPLACE (State or foreign country): Glasgow, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry C. Schnell
BIRTHPLACE: Mo.

14. MOTHER'S MAIDEN NAME: Elizabeth Reissaus
BIRTHPLACE: Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 516-10-5509

17. INFORMANT'S OWN SIGNATURE: x Carrie L. Schnell
ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive failure due 3979

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Ulcerative Heart disease

DUE TO (c) Arteriosclerotic Heart disease With Subacute Pulmonary Edema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-26-, 1968, *to* 12-10-, 1969, *that I last saw the deceased alive on* 12-10-, 1969, *and that death occurred at* 6:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph E. Wilson MD

23b. ADDRESS: Moscow Idaho

23c. DATE SIGNED: 12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec 12, 1969

24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery

24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: Dec. 12, 1969

REGISTRAR'S SIGNATURE: Mayne R Heishari

25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525
FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 3 0 1969

JUL 2 4 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5814
Local Reg. No. 145
Reg. Dist. No. 200

BIRTH NO.

RECEIVED DEC 23 1969

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Moscow Bureau of Vital Statistics
LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 114 South Almon

3. NAME OF DECEASED (Type or Print)
a. (First): Eathel
b. (Middle): Mae
c. (Last): Baud

4. DATE OF DEATH: (Month) December (Day) 12 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: September 16, 1917

9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid
10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Whitman County, Washington

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Levi Baud
BIRTHPLACE: Washington

14. MOTHER'S MAIDEN NAME: Maude Ice
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-24-2821

17. INFORMANT'S OWN SIGNATURE: X Bernadine B. Montgomery
ADDRESS: San Francisco, Cal.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) basilar skull fx
DUE TO (c) car-pedestrian accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. fracture cervical spine

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 1st & Main 04
21c. (CITY, TOWN, OR TOWNSHIP): Moscow 13291 (COUNTY): Latah (STATE): Idaho

21d. TIME OF INJURY (Month) 12 (Day) 12 (Year) 69 (Hour) 7:15 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: stepped in front of car

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title): Coroner
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 12/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-15-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1969
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 7 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5815
Local Reg. No. 147
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 226 East 1st

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Iris	May	Humphrey	Dec. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Aug. 19, 1897	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	at home	Prophetstown, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Burton C. Rowe	Newbedford, Illinois	May L. Morrill	Yorktown, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-46-6746A	X Chas. Humphrey	Moscow, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Chronic nephritis — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, *19* 62, *to* Dec., _____, *19* 69, *that I last saw the deceased alive on* 12-14-6919, *and that death occurred at* 3 a. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. P. Marineau, M. D.	129 W. Third St. Moscow, Idaho	12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	12-14-1969	Hazen & Jaeger Crematory	Spokane Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-23-69	Dolores Lettenmaier (Deputy)	NOT EMBALMED	

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. MAY 19 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5816
Local Reg. No. 148
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
c. LENGTH OF STAY (in this place): 23 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Own Home ooo Kendrick, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Alfred
b. (Middle):
c. (Last): Cann

4. DATE OF DEATH: (Month) Dec. (Day) 17 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 14, 1902

9. AGE (In years last birthday): 67
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Genesee, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Paul Cann
BIRTHPLACE: Ontario, Canada

14. MOTHER'S MAIDEN NAME: Emma Roderick
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-09-7427

17. INFORMANT'S OWN SIGNATURE: X Arnold J. Cann Jr.
ADDRESS: Pierce, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial infarct
INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 4 (Degree or title)
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 22 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-20-1969
24c. NAME OF CEMETERY OR CREMATORY: Gold Hill Cemetery
24d. LOCATION (City, town, or county) (State): Kendrick, Idaho

DATE REC'D BY LOCAL REG.: 12/31/69
REGISTRAR'S SIGNATURE: Wayne R Weiskari

25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525
FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5817
Local Reg. No. 149
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 112 N. Lilly

3. NAME OF DECEASED (Type or Print): a. (First) Jessie; b. (Middle) Pearl; c. (Last) Carter

4. DATE OF DEATH: (Month) 12; (Day) 17; (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 15, 1884

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Big Bear Ridge, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Abram Whitley
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Abbie Stuart
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-60-7553

17. INFORMANT'S OWN SIGNATURE: X C. M. Fitzsimmons
ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ileus (intestinal) — 4 days
DUE TO (c) Coronary (Heart) Blood Vessel Dis. — 1 week

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility - atherosclerosis — ?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 2-4, 1943, *to* 12-17, 1969, *that I last saw the deceased alive on* 12-17, 1969, *and that death occurred at* 4:15 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 149 Paul N Dennis MD

23b. ADDRESS: Moscow Idaho

23c. DATE SIGNED: 12-20 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-19-1969

24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery

24d. LOCATION (City, town, or county) (State): Moscow Cemetery

DATE REC'D BY LOCAL REG.: 12-24-69

REGISTRAR'S SIGNATURE: Delores Letterman (Deputy)

25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5818
Local Reg. No. 1
Reg. Dist. No. 200

69-12643
BIRTH NO.

RECEIVED JAN 13 1970 Bureau of Vital Statistics STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. [ICA 38-206 and 215.] Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY IN (this place): 5 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Park Village Apt. 24

3. NAME OF DECEASED (Type or Print): a. (First) John; b. (Middle); c. (Last) Sheils

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 17, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Dec. 17, 1969

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours 5, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Moscow, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert T. Sheils
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Carol Williamson
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: X R. Timothy Sheils
ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-17-69, 19__, *to* 12-17-69, 19__, *that I last saw the deceased alive on* 12-17-69, 19__, *and that death occurred at* 8:40A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. P. Marineau, M. D. 328

23b. ADDRESS: 129 W. Third St. Moscow, Ida.

23c. DATE SIGNED: 12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Buried

24b. DATE: Dec. 18, 1969

24c. NAME OF CEMETERY OR CREMATORY: Moscow Catholic Cemetery

24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: 7 Jan 1970

REGISTRAR'S SIGNATURE: Wayne R. Weikert

25. EMBALMER: Donald Ward

LICENSE NO.: E-80

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5819
Local Reg. No. 150
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 6 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah County Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
d. STREET ADDRESS (If rural, give location): Kendrick

3. NAME OF DECEASED (Type or Print)
a. (First): Bertha
b. (Middle): Mae
c. (Last): Eldridge

4. DATE OF DEATH: (Month) December (Day) 19, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 17, 1887

9. AGE (In years last birthday): 82
IF UNDER 1 YEAR — Months: 3 Days: 2
IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Mc Ewan, Oregon

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William C. Jones
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Ellen Turman
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: No Record

17. INFORMANT'S OWN SIGNATURE: L. E. Eldridge
ADDRESS: Kendrick, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Ruptured aortic Aneurysm
INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4419

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Dec, 1969, *that I last saw the deceased alive on* Dec. 18, 1969, *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 18 Edward T Boas MD
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 12-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 22, 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Gardens
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12/30, 1969
REGISTRAR'S SIGNATURE: Wayne R Weikart
25. EMBALMER: W. E. Black W. E. Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5820
Local Reg. No. 4
Reg. Dist. No. 200

RECEIVED JAN 13 1970 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 124 N. Main St.

3. NAME OF DECEASED (Type or Print)
a. (First) ORVILLE
b. (Middle) LEE
c. (Last) VASSAR

4. DATE OF DEATH (Month) (Day) (Year) December 19, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH September 23, 1922
9. AGE (In years last birthday) 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm labor 04
10b. KIND OF BUSINESS OR INDUSTRY Wheat Farm
11. BIRTHPLACE (State or foreign country) Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Luther L. Vassar — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Louella M. Miller — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War 2 4
16. SOCIAL SECURITY NO. 519-12-5088
17. INFORMANT'S OWN SIGNATURE Thelma K. McCrory — ADDRESS Palouse, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

929X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subdural hematoma — INTERVAL BETWEEN ONSET AND DEATH 72 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Apparent Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Undetermined 00
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13000
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? Undetermined

22. *I hereby certify that I attended the deceased from* 12-17-69, *19*___, *to* 12-19-69 *19*___, *that I last saw the deceased alive on* 12-17-69, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) W. P. Marineau, M. D. 328
23b. ADDRESS 129 W. Third St. Moscow, Ida.
23c. DATE SIGNED 12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-22-69
24c. NAME OF CEMETERY OR CREMATORY Freeze Cemetery
24d. LOCATION (City, town, or county) (State) Latah County, Idaho

DATE REC'D BY LOCAL REG. 7 Jan 1970
REGISTRAR'S SIGNATURE Wayne K. Heiskoi
25. EMBALMER E. A. Ellithorpe
LICENSE NO. 1280

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Kimball Funeral Home, Palouse, Wa.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5821
Local Reg. No. 151
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 5 1970 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle):
c. (Last): Erickson

4. DATE OF DEATH (Month) (Day) (Year): December 21 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: October 24, 1879
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Holten — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-09-5698B
17. INFORMANT'S OWN SIGNATURE: H. E. Erickson — ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 25 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic coronary disease — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Bronchial Asthma

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-19-69, 19___, *to* 12-21-, 1969, *that I last saw the deceased alive on* 12-21, 1969, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wenzel A Lopp M D 751
23b. ADDRESS: Pullman Washington
23c. DATE SIGNED: 12-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-23-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: 12/29/69
REGISTRAR'S SIGNATURE: Wayne R Hinkovic
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 7 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 16 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5822
Local Reg. No. 152
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 5 1970 Vital Statistics Bureau of Health

1. PLACE OF DEATH
a. COUNTY: Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Troy
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Troy, Idaho 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Benton 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Corvallis
d. STREET ADDRESS (If rural, give location): 410 S.W. Twin Oaks Circle

3. NAME OF DECEASED (Type or Print): a. (First) William—Hobart b. (Middle) McKinley c. (Last) Helms

4. DATE OF DEATH: (Month) December (Day) 21 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: November 11, 1897

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 38

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Arlington, Oregon

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Helms
BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Ora Nordike
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 542-12-5683A

17. INFORMANT'S OWN SIGNATURE: Doris C. Helms
ADDRESS: Corvallis, Or

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Congestive Heart Disease — year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Carcinoma of the Bladder. — year

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-13, 1969, *to* 12-21, 1969, *that I last saw the deceased alive on* 12-20, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Omer H Drury 148 (Degree or title) M.D.
23b. ADDRESS: Troy Idaho.
23c. DATE SIGNED: 12-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-23-1969
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: 12/29/69
REGISTRAR'S SIGNATURE: Wayne R Weisbrod
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5823
Local Reg. No. 153
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 29
b. CITY OR TOWN Moscow
LENGTH OF STAY (in this place) 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Latah 29
c. CITY OR TOWN Moscow
d. STREET ADDRESS 420 South Polk (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ora	Belle	Sittkus	December 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 14, 1887	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaker	Miltonvale, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Hileman	Kansas	Murila Jane Apple	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	536-18-0713-A	X Jeff Lewis	Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Auricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease
DUE TO (c) Arteriosclerotic Heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Recent Thrombophlebitis Hiatus hernia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	None	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-14-68, 19 68, *to* 12-26-68, 19 68, *that I last saw the deceased alive on* 12-20, 19 69, *and that death occurred at* 3:22 AM m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orval A. Wilson MD	Moscow Idaho	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 29, 1969	Moscow Cemetery	Moscow Latah Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/30/69	Wayne R Heiskasi	Donald Ward	E-380

FIRM NAME: Short's Funeral Chapel Moscow, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

APR 16 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5824
Local Reg. No. 3
Reg. Dist. No. 200

RECEIVED JAN 13 1970 Vital Statistics Bureau

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Charles	Thomas	McCarthy	Dec 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	White	Never married	1-10-1876	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired 28		Erie, Penn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
no record		No record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	533-12-2235A	L.A.Wallace,	Kendrick, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractured hip — 3-4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4369

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 1967, *to* Dec. 1969, *that I last saw the deceased alive on* Dec. 26, 1969, *and that death occurred at* 7:05P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward J. Bass MD	Moscow, Idaho	1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Dec.30,1969	Kendrick Cemetery	Kenderick, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
5 Jan 1970	Mayne R Heistand	Andrew F. Vassar	E315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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DEC 31 1969

RECEIVED

JAN 13 1970

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5825
Local Reg. No. 2
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Tip Top Restraunt 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 915 Harold

3. NAME OF DECEASED (Type or Print)
a. (First): Janice
b. (Middle): Lynn
c. (Last): Foiles

4. DATE OF DEATH (Month) (Day) (Year): December 28 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Sept. 18, 1951
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 63
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Coeur d' Alene, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Marvin Foiles — BIRTHPLACE: Loveland, Colo.
14. MOTHER'S MAIDEN NAME: Carma Worden — BIRTHPLACE: Loveland, Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-66-3553
17. INFORMANT'S OWN SIGNATURE: X Edward T. Knecht — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

968X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) cerebral laceration — "
DUE TO (c) multiple skull fractures

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Tip Top Cafe
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Moscow 13291 Latah Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 28 69 8p m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: hit c̄ heavy jagged instrument

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 8p m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. Kritzmann 583 4 Coroner
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 2 Jan 70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-2-1970
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: 5 Jan 1970
REGISTRAR'S SIGNATURE: Wayne R Heiskari
25. EMBALMER: E. Pete Albertson
LICENSE NO.: E-525

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 4 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 3 1 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5826
Local Reg. No. 890
Reg. Dist. No.

BIRTH NO.

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Charles; b. (Middle) Lewie; c. (Last) Jeep

4. DATE OF DEATH (Month) (Day) (Year): Dec. 3, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 15, 1893

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): construction work

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Colorado

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: unknown
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: unknown
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW #1 3

16. SOCIAL SECURITY NO.: 546 16 4219

17. INFORMANT'S OWN SIGNATURE: Joe W. Roberts
ADDRESS: Challis Ida.

18. CAUSE OF DEATH 5150
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): silicosis
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): none
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac decompensation

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-16-69, 19____, *to* 12-3-69, 19____, *that I last saw the deceased alive on* 12-3, 19 69, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 263
(Degree or title): MD
23b. ADDRESS: Box 769 Salmon, Idaho
23c. DATE SIGNED: 12-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 6, 1969
24c. NAME OF CEMETERY OR CREMATORY: Challis
24d. LOCATION (City, town, or county) (State): Challis, Idaho

DATE REC'D BY LOCAL REG.: Dec 22 69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369
FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5827
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 DEC 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 30 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Roy
b. (Middle): Clifton
c. (Last): Cope

4. DATE OF DEATH (Month) (Day) (Year): Dec. 11, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: June 27, 1893

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired businessman

10b. KIND OF BUSINESS OR INDUSTRY: 22

11. BIRTHPLACE (State or foreign country): Hartville, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James F. Cope
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Elizabeth Graven
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW #1 3

16. SOCIAL SECURITY NO.: 519-36-5912

17. INFORMANT'S OWN SIGNATURE: Maude Benedict
ADDRESS: Salmon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Cerebrovascular disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6/14, 1968, *to* 12/11, 1969, *that I last saw the deceased alive on* 12/11, 1969, *and that death occurred at* 11:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 263 MD
23b. ADDRESS: Box 769, Salmon, Idaho
23c. DATE SIGNED: 12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 13, 1969
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Dec-22-69
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369
FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5828
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 JAN 5 1970
b. CITY OR TOWN: Salmon
c. LENGTH OF STAY IN THIS PLACE: 11 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): home 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 300
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Janet	Kay	Studebaker	Dec. 17, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	May 21, 1935	34				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
home 01		Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred R. Robson	Missouri	Alverda Landon	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-34-0426	Harold V. Studebaker	Salmon, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Unknown	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	unknown	—
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Gastro Enteritis Congestion Lungs	—

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
	None	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
None m.		

22. *I hereby certify that I attended the deceased from* 1955, 19___, *to* death, 19___, *that I last saw the deceased alive on* 1965, 19___, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. L. Blackadar M.D. 045	Salmon, Ida	12-23-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 22, 1969	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 30th 69	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 28 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 15 1970 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5829
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): life 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi 302
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Salmon
d. STREET ADDRESS (If rural, give location): Lund Ranch

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Glen	Henry	Wyant	Dec. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Mar. 9, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
State HiWay & City 08	retired	Bohannon Creek, Lemhi Co. Ida	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clarence Wyant	Silver Bow, Montana	Ella Stotler	Union, Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-10-2142	Jack Wyant	Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4-3-64, 19____, *to* 12-30-69, 19____, *that I last saw the deceased alive on* 12-29, 19 69 *and that death occurred at* 7:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
263	Box 769 Salmon, Idaho	1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jan. 2, 1970	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan-12-70	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 19 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5830
Local Reg. No. 690
Reg. Dist. No.

RECEIVED JAN 1 5 1970 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Lemhi (30)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial (17)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer (19)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Elizabeth	Frances	Chivers	Dec. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	Oct. 22, 1886	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
home (01)		Custer, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George B. Thompson	Maine	Belle W. Riley	Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-42-9673 B	Ethel B Phelps	Challis, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral thrombosis.	1 wk.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis.	1 yr.
(c)	Recent bowel resection for strangulated hernia	6 wks.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Fract left hip —	2 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1966 19__, *to* death, 19__, *that I last saw the deceased alive on* Dec 31, 1969, *and that death occurred at* 9P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Hamilton MD (045)	Salmon, Idaho	1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial (3)	Jan. 3, 1970	Challis	Challis, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 12 70	Viola E Johnson	Gilbert C Jones	E 369

FIRM NAME: JONES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

JAN 19 1971

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

3 copies

Certificate of Death

STATE OF IDAHO

State File No. 5831
Local Reg. No. 1
Reg. Dist. No. 237

BIRTH NO.

RECEIVED JAN 22 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Lewis 3/C
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Craigmont
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Craigmont Clinic pod

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Lewis 3/C
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nezperce
d. STREET ADDRESS (If rural, give location) 706 Oak

3. NAME OF DECEASED (Type or Print) a. (First) Daisy b. (Middle) Marie c. (Last) Grunewald

4. DATE OF DEATH (Month) Nov (Day) 21 (Year) 1969

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Dec 12 1902

9. AGE (In years last birthday) 66
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Kamiah, Idaho

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME BIRTHPLACE Rufus Lomax

14. MOTHER'S MAIDEN NAME BIRTHPLACE Julia Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 42 6662

17. INFORMANT'S OWN SIGNATURE ADDRESS John A. Davis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8837

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 mins

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Possibly but secondary — 4 days
DUE TO (c) to injury of Rt leg & Knee

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify) /

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 05 Rochdale Co.

21c. (CITY, TOWN, OR TOWNSHIP) 3310 (COUNTY) Nez Perce, (STATE) Ida

21d. TIME OF INJURY (Month) 11 (Day) 17 (Year) 69 (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK XX NOT WHILE AT WORK ☐

21f. HOW DID INJURY occur? Fell through a hole in the floor left by burglers

22. I hereby certify that I attended the deceased from 11-17, 1969 to 11-21, 1969, that I last saw the deceased alive on 11-21, 1969, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 935

23b. ADDRESS Craigmont, Ida.

23c. DATE SIGNED 1/12/70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov 25 1969

24c. NAME OF CEMETERY OR CREMATORY Kamiah Cemetery

24d. LOCATION (City, town, or county) Kamiah, (State) Idaho

DATE REC'D BY LOCAL REG. 1/20/69

REGISTRAR'S SIGNATURE

25. EMBALMER

LICENSE NO. E 421

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 22 1970
JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5832
Local Reg. No. 701
Reg. Dist. No. 430

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Lincoln 320 — DEC 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone — Bureau of Vital Statistics
c. LENGTH OF STAY (In this place): 6 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richfield
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	C.	ALBRETHSEN	Dec.	17,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	Nov. 20, 1885	84	0	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Copenhagen, Denmark
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Albert Albrethsen — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Hannah Larsen — BIRTHPLACE: Denmark
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-56-7548J1
17. INFORMANT'S OWN SIGNATURE: X Norman C. Albrethsen — ADDRESS: Richfield Ida.

4379

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Self Imposed Starvation	3 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral Arteriosclerosis	3 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1969 *to* December 17, 1969, *that I last saw the deceased alive on* December 17, 1969, *and that death occurred at* 5:30 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD 386
23b. ADDRESS: Shoshone Idaho
23c. DATE SIGNED: 12/18/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-20-69
24c. NAME OF CEMETERY OR CREMATORY: Carey Cemetery
24d. LOCATION (City, town, or county) (State): Carey, Idaho

DATE REC'D BY LOCAL REG.: 12-19-69
REGISTRAR'S SIGNATURE: Frances M. Bergin
25. EMBALMER: Frances M. Bergin
LICENSE NO.: E-463
FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5833
Local Reg. No. 702
Reg. Dist. No. 430

Certificate of Death

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (In this place): 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln 320
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richfield
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): SEVERE
c. (Last): McINTOSH

4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 7, 1886
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 5, Days 0 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Denlow, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Mose McIntosh — BIRTHPLACE: ---
14. MOTHER'S MAIDEN NAME: Charity — BIRTHPLACE: ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-40-6296
17. INFORMANT'S OWN SIGNATURE: + Helen Storey — ADDRESS: Hill City, Ida

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic / pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteria Sclerotic Heart Disease — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December, 1968, *to* Dec 23, 1969, *that I last saw the deceased alive on* Dec 22, 1969, *and that death occurred at* 1:15 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 386
23b. ADDRESS: Box 68 Shoshone Idaho
23c. DATE SIGNED: 12-26-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-27-1969
24c. NAME OF CEMETERY OR CREMATORY: Richfield Cemetery
24d. LOCATION (City, town, or county) (State): Richfield, Idaho

DATE REC'D BY LOCAL REG.: 12-28-69
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended January 13, 1970

Certificate of Death
STATE OF IDAHO

State File No. 5834
Local Reg. No. 703
Reg. Dist. No. 430

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 346 Matthews Senior Citizens Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 1137 Colorado St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Troy	Preston	Cox	December 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Sept 8, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 08: Retired-Water Supt. & Commissioner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co., Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Levi Wilburn Cox	Virginia	Alice Moore	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW #1 3	519-30-3286-a	Carl W. Cox	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Artery Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 10 yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 11, 19 69, *to* Dec 26, 19 69, *that I last saw the deceased alive on* Dec 24, 19 69, *and that death occurred at* 11:40A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. G. Neher, M.D. 386.	Shoshone, Idaho	1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-29-1969	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-3-1970	Francis M. Bergin	Eddie G. Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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1-12-70

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of Ada

Certificate No.

Date Filed Jan 5, 1970

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Troy Preston Cox (Name on Original Certificate) who died (Was Born or Died) on Dec. 26, 1969 (Date of Event)
in Shoshone, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 13	Wilbur Cox	Levi Wilburn Cox

Subscribed and sworn to before me this 13th day of January, 1970

Notary Public, residing at Boise, Idaho

My commission expires April 24, 1970

(Seal)

X Signed Irene Faulkner
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

7805 Ustick Rd - Boise 83704
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 13th day of January, 1970

Notary Public, residing at Boise, Idaho

My commission expires April 24, 1970

(Seal)

X Signed Carl W. Cox
(Signature of Any Credible Person)

607 Beeson St., Boise, Idaho 83706
(Street Address, City, State)

FORM DH 60-155

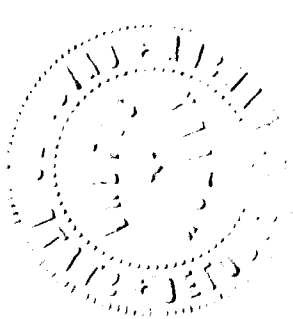
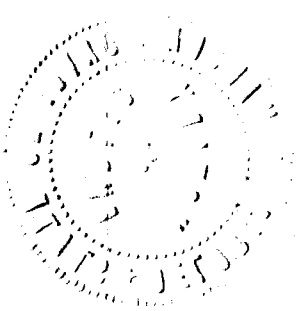

Certificate of Death

STATE OF IDAHO

RECEIVED

JAN 5 1970

Bureau of Vital Statistics

State File No.
Local Reg. No. 703
Reg. Dist. No. 430

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: Matthews Senior Citizens Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 1137 Colorado St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Troy	Preston	Cox	Dec. 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Sept. 8, 1888	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired--Water Supt.	Commissioner	Carroll Co. Va.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wilbur Cox	Virginia	Alice Moore	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WWI #1	$19-30-3286-A	Carl W. Cox	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Artery Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec 11, 1969, to Dec 26, 1969, that I last saw the deceased alive on Dec 26, 1969, and that death occurred at 11:40 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Box 68 Thornton Idaho	1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-29-1969	Elmwood Cemetery	Gooding Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-3-1970	Francis M. Bergin	Eddie G. Leach	E-511

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 6 1970
JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5835
Local Reg. No. 77
Reg. Dist. No. 630

BIRTH NO.

RECEIVED DEC 8 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 331 Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
c. LENGTH OF STAY (in this place) 60 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Madison Memorial 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) 352 S. 2 W.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	William	Siepert	Dec.	1,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Married	June 26, 1893	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher- Stockman 04
10b. KIND OF BUSINESS OR INDUSTRY Cattle Raising
11. BIRTHPLACE (State or foreign country) Burton, Idaho
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Roman Siepert — BIRTHPLACE Muhringen, Horb, Wustenberg, Germany
14. MOTHER'S MAIDEN NAME Maria Ellen Young — BIRTHPLACE Provo, Utah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-9723
17. INFORMANT'S OWN SIGNATURE Mark William Siepert — ADDRESS Rexburg, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 11 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. First Coronary Thrombosis 2 yrs ago.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1947 *to* Dec. 1, 1969, *that I last saw the deceased alive on* Dec. 1, 1969, *and that death occurred at* 6:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. L. Bigby M.D.	Rexburg Idaho	Dec. 3 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/4/69	Rexburg, Cemetery	Rexburg, Madison, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-4-69	Leona Flamm	Russel Flamm	E-254

FIRM NAME: Flamm Fineral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5836
Local Reg. No. 72
Reg. Dist. No. 630

BIRTH NO.

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): EVD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 213 E. 2 So.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
David Heber		Manwaring	December 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cauc.	Married	June 29, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate Salesman 24	Retired - Dairyman	Mapleton, Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herbert Manwaring	England Sandbatch, Cheshire	Clarissa Wilkins	Willard, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-07-3914	D. Blair Manwaring	Rexburg, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute myocardial infarction	15 min.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Myocardial Ischemia	10 years
DUE TO (c)	Arterio-sclerotic cardio-vascular disease	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March, 1954, *to* Dec 7, 1961, *that I last saw the deceased alive on* Dec 7, 1969, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Blair Manwaring	MD	Rexburg Idaho	12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12/10/1969	Little Butte Cemetery	Annis, Jefferson, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-10-69	Lena Flamm	Russell Flamm	E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 18 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 16 1981

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5837
Local Reg. No. 73
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 18 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
c. LENGTH OF STAY (in this place) 9 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) 15 So. 1 West

3. NAME OF DECEASED (Type or Print)
a. (First) Alma
b. (Middle) Jay Christensen
c. (Last)

4. DATE OF DEATH (Month) Dec. (Day) 9, (Year) 1969

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 12, 1918
9. AGE (In years last birthday) 51 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bussiness Manager 17
10b. KIND OF BUSINESS OR INDUSTRY Lumber Business
11. BIRTHPLACE (State or foreign country) Oasis, Millard Co., Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Alma Joshua Christensen — BIRTHPLACE Oasis, Utah
14. MOTHER'S MAIDEN NAME Sylvia Boletta Christensen — BIRTHPLACE Oak City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World Wra 11 4
16. SOCIAL SECURITY NO. 528-18-4255
17. INFORMANT'S OWN SIGNATURE Donna Christensen — ADDRESS 15 S 1 W. Rexburg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

575X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Irreversible Shock — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hemorrhage at Surgery — 12 hours.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Anuria — 12 hours.

19a. DATE OF OPERATION 12-9-69
19b. MAJOR FINDINGS OF OPERATION Acute & Chronic gangrenous cholecystitis
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-25, 1968, *to* 12-9-, 1969, *that I last saw the deceased alive on* 12-9, 1969, *and that death occurred at* 9:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 409. (Degree or title) [signature]
23b. ADDRESS Rexburg Idaho
23c. DATE SIGNED 12-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 12/12/69
24c. NAME OF CEMETERY OR CREMATORY Washtach Lawn Cemetery
24d. LOCATION (City, town, or county) (State) Salt Lake City, Utah

DATE REC'D BY LOCAL REG. 12-12-69
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER Russel Flamm — LICENSE NO. E-254
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5838
Local Reg. No. 74
Reg. Dist. No. 630

BIRTH NO.

RECEIVED DEC 18 1969 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY 331 Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DTO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison 331
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) 128 Webster Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George		Murri	Dec.	10,	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Married	Oct. 25, 1907	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sexton Foreman 10	Railroad	St Anthony, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gottfred Murri	Scherli, Bern Switzerland	Christena Miller	Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	712-07-7962	Ernest J Murri	971 Bannock, Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, *1961, to* Dec. 10, *1969, that I last saw the deceased alive on* Dec. 10, *1969, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Rexburg Idaho	Dec 10 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/13/69	Parker Cemetery	Parker, Fremont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-13-69	Leona Flamm	Russel Flamm	E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 22 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5839
Local Reg. No. 75
Reg. Dist. No. 630

BIRTH NO.

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison (331)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): Abt 3 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 150 East 2nd South

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah (45)
b. COUNTY: Utah (555)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Provo
d. STREET ADDRESS (If rural, give location): ~~Apt C, 150 East 2nd South, Rexburg, Idaho~~ 702 South Utah Ave

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	REBECCA	LEANORE	BEESLEY	December 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Never Married	July 3, 1951	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student (03)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Provo, Utah
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: David Beesley — BIRTHPLACE: Provo, Utah
14. MOTHER'S MAIDEN NAME: Geaniel Vincent — BIRTHPLACE: Eureka, Utah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 9229
17. INFORMANT'S OWN SIGNATURE: Wayne O Beesley — ADDRESS: 702 South Utah Av Provo, Utah

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gun Shot Wound — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Accidental shooting
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): In home (31)
21c. (CITY, TOWN, OR TOWNSHIP) (3331) (COUNTY) (STATE): Rexburg, Madison County, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 12, 1969 4:35 P
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Gun shot, accidental

22. *I hereby certify that I attended the deceased from ____, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 4:35 P.m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): Coroner Madison County
23b. ADDRESS: P.O. Box 13, Rexburg, Ida
23c. DATE SIGNED: 15Dec1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 12/13/69
24c. NAME OF CEMETERY OR CREMATORY: Provo
24d. LOCATION (City, town, or county) (State): Provo, Utah — Utah

DATE REC'D BY LOCAL REG.: 12-13-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Kenneth W Flamm — LICENSE NO.: E347
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended February 10, 1970

Certificate of Death
STATE OF IDAHO

State File No. 5840
Local Reg. No. 82
Reg. Dist. No. 630

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Golden Living Center 347

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13
b. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 628 North Hayes

3. NAME OF DECEASED (Type or Print): a. (First) William; b. (Middle) Erastus; c. (Last) Gee

4. DATE OF DEATH: (Month) (Day) (Year): December 14, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct 17, 1875

9. AGE (In years last birthday): 94
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Employee 08

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Tooele, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Erastus Gee
BIRTHPLACE: Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME: Geneva Telford
BIRTHPLACE: Bountiful, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-26-0298

17. INFORMANT'S OWN SIGNATURE: Merrill Gee
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 1 da

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — several years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 19 69, *to* 12-14-, 19 69, *that I last saw the deceased alive on* 12-14, 19 69, *and that death occurred at* 7 pm, *from the causes and on the date stated above.*

23a. SIGNATURE: Lester J. Petersen, M.D. 413 (Degree or title)
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12-17-69
24c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Memorial Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: 12-31-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Kenneth Flamm
LICENSE NO.: E 347

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Manning Funeral Home, Pocatello

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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2-5-70

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
FEB 10 1970
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. 69-5840

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for William Erastus Gee (Name on Original Certificate) who died (Was Born or Died) on December 14, 1969 (Date of Event)

in Rexburg, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 10a	Retired	Public Employee
Item 13 Birthplace	Unknown	Salt Lake City, Utah
Item 14	Telford	Geneva Telford

Subscribed and sworn to before me this 10 day of February, 1970.

Hazel L. Hurlbert
Notary Public, residing at Eagle, Idaho
My commission expires Sept 30, 1972
(Seal)

X Signed Conway Grant **
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person)

318 No Latah, Boise Ida
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.
County of ..... }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 10 day of February, 1970.

Hazel L. Hurlbert
Notary Public, residing at Eagle, Ida
My commission expires Sept 30, 1972
(Seal)

X Signed [illegible]
(Signature of Any Credible Person)

318 No Latah, Boise Idaho
(Street Address, City, State)

FORM DH 60-155

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 14 birthplace	Unknown	Bountiful, Utah
Item 16	omitted	518-26-0298

**

Certificate of Death

STATE OF IDAHO

State File No. 5840
Local Reg. No. 82
Reg. Dist. No. 630

BIRTH NO.

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Golden Living Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 628 North Hayes

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Erastus
c. (Last): Gee

4. DATE OF DEATH (Month) (Day) (Year): December 14, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 17, 1875

9. AGE (In years last birthday): 94
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Tooele, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Erastus Gee
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Telford
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Merrill Gee
ADDRESS: Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial failure
INTERVAL BETWEEN ONSET AND DEATH: 1da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH: several years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1969, *to* 12-14, 1969, *that I last saw the deceased alive on* 12-14-, 1969, *and that death occurred at* 7 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lester J. Peterson MD

23b. ADDRESS: Rexburg Idaho

23c. DATE SIGNED: 12-31-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 12/17/69

24c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Memorial Gardens, Pocatello, Bannock, Idaho

24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: 12-31-69

REGISTRAR'S SIGNATURE: Joyce Flamm

25. EMBALMER: Kenneth A. Klamm

LICENSE NO.: E-347

FIRM NAME: Manning Funeral Home- Pocatello

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 2 - 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 14 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5841
Local Reg. No. 77
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 18 1969

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (If this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 045
b. COUNTY: Utah 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Provo
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): FRANK
b. (Middle): WARD
c. (Last): STAGG

4. DATE OF DEATH (Month) (Day) (Year): December 14, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: December 26, 1915
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Manager 26
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Castlegate, Utah
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Stagg — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Elizabeth Ward — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II 4319
16. SOCIAL SECURITY NO.: 528-10-8033
17. INFORMANT'S OWN SIGNATURE: Roland L Olsen — ADDRESS: 730 W 4 No Provo Ut.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Stroke - cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec 14, 1969, *to* Dec 14, 1969, *that I last saw the deceased alive on* Dec 14, 1969, *and that death occurred at* 1:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Rex G. Mabey MD 317 (Degree or title)
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify): 3 Removal
24b. DATE: 12/15/69
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Provo Utah Utah

DATE REC'D BY LOCAL REG.: 12-15-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Kenneth Flamm — LICENSE NO. E347

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 2 9 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 2 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 1 4 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5842
Local Reg. No. 80
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 29 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 33
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 1 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Teton, Idaho
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ERNEST
b. (Middle): HERMAN
c. (Last): QUIRL

4. DATE OF DEATH (Month) (Day) (Year): Dec 15, 1969

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: 3 May 1888
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (State or foreign country): Round Mountain, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John N. Quirl — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Letha E. Smith — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 519-42-9905
17. INFORMANT'S OWN SIGNATURE: Brent Quirl — ADDRESS: Teton, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma - Head of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Age - Obstruction of Common Duct — 1 month.

19a. DATE OF OPERATION: Nov 18 1969
19b. MAJOR FINDINGS OF OPERATION: Carcinoma - Head of Pancreas - Obstruction Common Duct
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1956, *to* Dec 15, 1969, *that I last saw the deceased alive on* Dec 14, 1969, *and that death occurred at* 12:10AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Blair H Passey 409 (Degree or title) MD.
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: 12-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 17 Dec 69
24c. NAME OF CEMETERY OR CREMATORY: Teton-Newdale Cemetery
24d. LOCATION (City, town, or county) (State): Sugar City, RFD, Idaho

DATE REC'D BY LOCAL REG.: 12-17-69
REGISTRAR'S SIGNATURE: Leona Flamen
25. EMBALMER: M. D. Hansen — M D Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 9 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 19 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 2 1985

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-12715

BIRTH NO.

Certificate of Death

STATE OF IDAHO

State File No. 5843
Local Reg. No. 81
Reg. Dist. No. 630

RECEIVED DEC 29 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 2 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ririe
d. STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print)
a. (First): LEONA
b. (Middle): LUZON
c. (Last): McMURTREY

4. DATE OF DEATH (Month) (Day) (Year): Dec. 16, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Dec. 16, 1969
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.: 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: Child
11. BIRTHPLACE (State or foreign country): Rexburg, Idaho.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Buddy James McMurtrey — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Gail Renee Blakely — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: B. James McMurtrey — ADDRESS: Ririe, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

777X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Prematurity (6 mos. Gestation)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 16, 1969, *to* Dec 16, 1969, *that I last saw the deceased alive on* Dec 16, 1969, *and that death occurred at* 7:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Blanche A. Rexsey 409 (Degree or title) M.D.
23b. ADDRESS: Rexburg, Idaho.
23c. DATE SIGNED: 12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3
24b. DATE: Dec. 18, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rigby Pioneer
24d. LOCATION (City, town, or county) (State): Rigby Jefferson Idaho.

DATE REC'D BY LOCAL REG.: 12-20-69
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Bruce A. Eckersell — Bruce A. Eckersell
LICENSE NO.: E-404

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Eckersell Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5844
Local Reg. No. 97
Reg. Dist. No. 450

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 312 A Street

3. NAME OF DECEASED (Type or Print)
a. (First) Arvilla
b. (Middle)
c. (Last) Mathews

4. DATE OF DEATH (Month) (Day) (Year) Dec 4 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Mar 2 1907
9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer-Hospital 06
10b. KIND OF BUSINESS OR INDUSTRY Kitchen
11. BIRTHPLACE (State or foreign country) Lewiston Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hyrum Neibar — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Alice Millward — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 544-26-6895
17. INFORMANT'S OWN SIGNATURE Mrs. Harlo Felton — ADDRESS 1510 "D" Street Heyburn-Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH 12 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cardiac decompensation — 3 weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Myocardial infarction — 6 weeks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 21, 1969, *to* Dec. 4, 1969, *that I last saw the deceased alive on* Dec. 3, 1969, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) A C Truxal, M.D.
23b. ADDRESS Rupert, Idaho
23c. DATE SIGNED 12-5-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 8 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-22-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Robert C Walk — LICENSE NO. E 294
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5845
Local Reg. No. #93
Reg. Dist. No. #20

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
LENGTH OF STAY (In this place): 4 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Hulda; b. (Middle); c. (Last) BEECH

4. DATE OF DEATH (Month) (Day) (Year): December 5, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 30, 1885

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Griswold, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Nelson
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Malena Hanson
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): — — —

16. SOCIAL SECURITY NO.: 518-24-4973

17. INFORMANT'S OWN SIGNATURE: Minidoka Memorial Hospital, Rupert, Idaho
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4489

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Decompensated heart disease.
INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c) Age.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 1966, *to* 5 Dec, 1969, *that I last saw the deceased alive on* 5 Dec, 1969, *and that death occurred at* 1:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: W W Crawford 340 MD (Degree or title)
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 11 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 9, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: 12-15-69
REGISTRAR'S SIGNATURE: Mary Esther Carlson
25. EMBALMER: Charles H Peterson
LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 16 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5846
Local Reg. No. 90
Reg. Dist. No. 450

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) East Third Street (Rt. 1)

3. NAME OF DECEASED (Type or Print)
a. (First) Joseph
b. (Middle) John
c. (Last) KRIVANEC

4. DATE OF DEATH (Month) (Day) (Year) December 7, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH August 14, 1887
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Strakonice, Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jan Krivanec — BIRTHPLACE Czechoslovakia
14. MOTHER'S MAIDEN NAME Josefa Rezanka — BIRTHPLACE Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - -
16. SOCIAL SECURITY NO. 518-20-8173
17. INFORMANT'S OWN SIGNATURE Rosa Goff — ADDRESS Rupert, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A.S.C.V.R. — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1966, *to* 12-7-69, 19___, *that I last saw the deceased alive on* 12-6-69, 19___, *and that death occurred at* 4:00 *A.M., from the causes and on the date stated above.*

23a. SIGNATURE Sam K. Humphrey MD 253 (Degree or title)
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 12-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 10, 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert, Idaho

DATE REC'D BY LOCAL REG. 12-15-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Charles H Parsons
LICENSE NO. E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. SEP 21 1976

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5847
Local Reg. No. 94
Reg. Dist. No. 450

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 16 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 21 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kathryn's Rest Home 319

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Albion
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Elsie
b. (Middle) Ines
c. (Last) TUTTLE

4. DATE OF DEATH (Month) (Day) (Year) December 7, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 7, 1896
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Eureka, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Petet Ulrich — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Lena Smith — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - -
16. SOCIAL SECURITY NO. 519-03-1612
17. INFORMANT'S OWN SIGNATURE Mrs. L. Tuttle — ADDRESS Albion Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: Several years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Diabetes mellitus

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-23, 1969, *to* Dec, 1969, *that I last saw the deceased alive on* 10 Nov, 1969, *and that death occurred at* 10:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 740 H W Crawford MD
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 11 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 11, 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert, Idaho

DATE REC'D BY LOCAL REG. 12-15-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Charles H Persons
LICENSE NO. E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5848
Local Reg. No. 22
Reg. Dist. No. 450

BIRTH NO.

RECEIVED DEC 16 1969 Vital Statistics Bureau Of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN: Rupert
c. LENGTH OF STAY (in this place): 20 mins.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert (rural)
d. STREET ADDRESS (If rural, give location): 300 East - 250 North (Rt. 4)

3. NAME OF DECEASED (Type or Print): a. (First) Calvin; b. (Middle) Lee; c. (Last) HEISEL

4. DATE OF DEATH (Month) (Day) (Year): December 8, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: August 23, 1926

9. AGE (In years last birthday): 43
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Morland, Kansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oscar E. Heisel
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Elizabeth Pfeifer
BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.II & Korea

16. SOCIAL SECURITY NO.: 519-22-2104

17. INFORMANT'S OWN SIGNATURE: Oscar E. Heisel
ADDRESS: Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Severe brain damage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 20 W 375 N of Rupert 06
21c. (CITY, TOWN, OR TOWNSHIP): Rupert 13340 (COUNTY): Minidoka (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12 8 69 8:45 P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8 Dec, 1969, *to* 8 Dec, 1969, *that I last saw the deceased alive on* 8 Dec, 1969, *and that death occurred at* 9:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. W. Crawford 140 (Degree or title): MD
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 11 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: 12-15-69
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Charles H Parsons
LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 17 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 30 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

certificate is being corrected.

bf 5-28-70

certificate is being corrected.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Crawford

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5849
Local Reg. No. 98
Reg. Dist. No. 450

BIRTH NO.

DEC 29 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 10 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 1009 4th street

3. NAME OF DECEASED (Type or Print)
a. (First) Knonley
b. (Middle) Foreman
c. (Last) Moffit

4. DATE OF DEATH (Month) (Day) (Year) Dec 14 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan 17 1883
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retrired Farmer and
10b. KIND OF BUSINESS OR INDUSTRY Carpenter
11. BIRTHPLACE (State or foreign country) Barron Wisconson
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Moffit — BIRTHPLACE Michigan
14. MOTHER'S MAIDEN NAME Lydia Houghtaling — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-03-1029
17. INFORMANT'S OWN SIGNATURE Ruby E. Moffit — ADDRESS Rupert Ida 1009 4th st

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infirmities of age.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1967, *to* 14 Dec, 1969, *that I last saw the deceased alive on* 14 Dec, 1969, *and that death occurred at* 2:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 746 H W Crawford MD (Degree or title)
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 22 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 17 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-23-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Robert C Walk — LICENSE NO. E 299
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Crawford

Certificate of Death

STATE OF IDAHO

State File No. 5850
Local Reg. No. 187
Reg. Dist. No. 410

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 806 2nd street

3. NAME OF DECEASED (Type or Print)
a. (First) Reinhold
b. (Middle) A.
c. (Last) Pflughoeft

4. DATE OF DEATH (Month) (Day) (Year) Dec 14 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct 9 1889

9. AGE (In years last birthday) 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ellsworth Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Pflughoeft
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Emilia Arndt
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-40-6369

17. INFORMANT'S OWN SIGNATURE Ellen F. Pflughoeft
ADDRESS Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH several months.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Decompensated heart disease
DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1968, *to* Dec 14, 1969, *that I last saw the deceased alive on* Dec 14, 1969, *and that death occurred at* 8:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Wal Crawford MD

23b. ADDRESS Rupert Idaho

23c. DATE SIGNED 22 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec 18 1969

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-31-69

REGISTRAR'S SIGNATURE Mary Ellen Barlow

25. EMBALMER Charles L Parsons

LICENSE NO. E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Crawford

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5851
Local Reg. No. 99
Reg. Dist. No. 450

BIRTH NO.

DEC 29 1969

Bureau of Vital

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert (rural)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 800 North - 277 East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert (rural)
d. STREET ADDRESS (If rural, give location) 800 North - 277 East

3. NAME OF DECEASED (Type or Print)
a. (First) Tori
b. (Middle)
c. (Last) SHIGIHARA

4. DATE OF DEATH (Month) (Day) (Year) December 16, 1969

5. SEX Female
6. COLOR OR RACE Japanese
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH December 27, 1895
9. AGE (In years last birthday) 73
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Fukushima Ken, Japan
12. CITIZEN OF WHAT COUNTRY? Japan

13. FATHER'S NAME Tetsunosuki Shigihara
BIRTHPLACE Japan
14. MOTHER'S MAIDEN NAME Yu Shigihara
BIRTHPLACE Japan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) - - -
16. SOCIAL SECURITY 518-44-1602
17. INFORMANT'S OWN SIGNATURE Gonie Shigihara
ADDRESS Rupert, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1969, *to* 16 Dec, 1969, *that I last saw the deceased alive on* 9 Dec, 1969, *and that death occurred at* 2:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) W W Crawford 740 M D
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 22 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3
24b. DATE Dec. 19, 1969
24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State) Burley, Idaho

DATE REC'D BY LOCAL REG. 12-23-69
REGISTRAR'S SIGNATURE Mary Ellen Jackson
25. EMBALMER Robert C Walk
LICENSE NO. E 294

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 2 9 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Dr Dalley

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5852
Local Reg. No. 100
Reg. Dist. No. 450

BIRTH NO.

DEC 29 1969

Bureau of V.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 3 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 302 Cresent Drive

3. NAME OF DECEASED (Type or Print)
a. (First) Joseph
b. (Middle) Elmore
c. (Last) Broadhead

4. DATE OF DEATH (Month) (Day) (Year) Dec 20 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct 22 1919
9. AGE (In years last birthday) 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Police Judge
10b. KIND OF BUSINESS OR INDUSTRY 08 Municipal
11. BIRTHPLACE (State or foreign country) Rupert Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Earl Broadhead — BIRTHPLACE Nephi Utah
14. MOTHER'S MAIDEN NAME Ada Carter — BIRTHPLACE Nephi, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes, U.S. Air Force W.W.11
16. SOCIAL SECURITY NO. 519 12 6964
17. INFORMANT'S OWN SIGNATURE Beth L. Broadhead — ADDRESS

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 hours.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriolar Sclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1956, *to* Dec, 1969, *that I last saw the deceased alive on* Dec 20, 1969, *and that death occurred at* 450 A m., *from the causes and on the date stated above.*

23a. SIGNATURE C F Dalley 127 (Degree or title) M W
23b. ADDRESS 702 G Rupert Idaho
23c. DATE SIGNED 12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 23 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-23-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Robert C Walk — LICENSE NO. E 794
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 0 1 2010

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 14 1970
Bureau of Vital Statistics

State File No. 5853
Local Reg. No. 2
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Minidoka 340	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn — STAY (In this place): 6 months	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 400 S 350 W 000	d. STREET ADDRESS (If rural, give location): 400 S 350 W

3. NAME OF DECEASED (Type or Print)	a. (First) Lloyd	b. (Middle) Garrison	c. (Last) Knight	4. DATE OF DEATH (Month) (Day) (Year) Dec. 23, 1969
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: Sept. 7, 1879	9. AGE (In years last birthday): 90 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister 18	10b. KIND OF BUSINESS OR INDUSTRY: Congregational	11. BIRTHPLACE (State or foreign country): Sheboygan, Wisconsin	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Henry F. Knight**	BIRTHPLACE: Gibbsville, Wis.	14. MOTHER'S MAIDEN NAME: Eliza J. Femmo**	BIRTHPLACE: Wauconda Lake, Ill.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service) * * *	16. SOCIAL SECURITY NO.: 542-32-5048	17. INFORMANT'S OWN SIGNATURE: Edith Armacost	ADDRESS: Heyburn	

4409

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	generalized arteriosclerosis with Atrial Fibrillation	years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Benign Prostatic Hypertrophy	years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-18, 1969, *to* 12-23, 1969, *that I last saw the deceased alive on* 12-11, 1969, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: W R Petersen 709 (Degree or title)	23b. ADDRESS: Burley, Idaho	23c. DATE SIGNED: 1.6.70
24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 3	24b. DATE: 12/24/69	24c. NAME OF CEMETERY OR CREMATORY: Mt. View Crematory
24d. LOCATION (City, town, or county): Boise	(State): Idaho	
DATE REC'D BY LOCAL REG.: 1-12-70	REGISTRAR'S SIGNATURE: Mary Ellen Carlson	25. EMBALMER: Jerry K. Lawson
LICENSE NO.: E-522		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Payne Mortuary-Burley

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5854
Local Reg. No. 102
Reg. Dist. No. 450

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JAN 2 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 424 1st street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 424 1st street

3. NAME OF DECEASED (Type or Print)
a. (First) Charles
b. (Middle) William
c. (Last) Simpson

4. DATE OF DEATH (Month) (Day) (Year) Dec 25 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Sept 8 1952
9. AGE (In years last birthday) 17 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Quincy Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Wm Baze — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Alice Lomeyer — BIRTHPLACE Quincy Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 567 94 8926
17. INFORMANT'S OWN SIGNATURE x James D. Simpson — ADDRESS Rupert Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

873X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia secondary to carbon monoxide poisoning

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home 32
21c. (CITY, TOWN, OR TOWNSHIP) 13340 (COUNTY) (STATE) Rupert, Minidoka County, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 25 1969 7P am M
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Apparently left motor of car running, accidently

22. *I hereby certify that I attended the deceased from* Did not see alive *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 583 Robert C Walk (Degree or title) Coroner
23b. ADDRESS 710 6th street Rupert Idaho
23c. DATE SIGNED 12 27 69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 30 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-31-69
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Robert C Walk — LICENSE NO. E 294

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5855
Local Reg. No. 105
Reg. Dist. No. 4 30

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN Rupert
(If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 135

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 163 South Meridian

3. NAME OF DECEASED (Type or Print) a. (First) Raymond b. (Middle) G.. c. (Last) Dowd

4. DATE OF DEATH (Month) (Day) (Year) Dec 28 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 4 1899

9. AGE (In years last birthday) 70
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Harrisonville Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Dowd
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Susan Ella Gilkeson
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 519-22-2744

17. INFORMANT'S OWN SIGNATURE Margie Dowd
ADDRESS Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4369

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular accident — INTERVAL BETWEEN ONSET AND DEATH 1-2-hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-28, 1960, *to* 1-3, 1966, *that I last saw the deceased alive on* D.O.A. 12-28-1969, *and that death occurred at* 11:45A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Ben K. Humphrey 253 MD
23b. ADDRESS 645-5th, Rupert, Ida.
23c. DATE SIGNED 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 31 1969
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-31-69
REGISTRAR'S SIGNATURE Mary Ellen Barlow
25. EMBALMER Robert C Walk E 794
LICENSE NO.
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5856
Local Reg. No. 7
Reg. Dist. No. 410

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Minidoka 340 JAN 13 1970
b. CITY OR TOWN Rupert
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 325

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 1014 10th street

3. NAME OF DECEASED (Type or Print)
a. (First) Delia
b. (Middle)
c. (Last) Workman

4. DATE OF DEATH (Month) (Day) (Year) Dec 31 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan 13 1880

9. AGE (In years last birthday) 89
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Preston Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Linstroth 0 BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME unknown BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-28-5260

17. INFORMANT'S OWN SIGNATURE Delia Workman ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 10 years
DUE TO (c) Bilateral pleural effusion — 2 weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 22, 19 69, *to* Dec. 31, 19 69, *that I last saw the deceased alive on* Dec. 30, 19 69, *and that death occurred at* 4:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) R C Lovell, M.D.

23b. ADDRESS Rupert, Idaho

23c. DATE SIGNED 1-3-70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jan 3 1970

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 1-9-70

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Charles D Parsons LICENSE NO. E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

6 copies.

Certificate of Death

STATE OF IDAHO

State File No. 5857
Local Reg. No. 306
Reg. Dist. No. 220

RECEIVED DEC 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nezperce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewistown
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Craigmont
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Keith
b. (Middle): P.
c. (Last): Hackwith

4. DATE OF DEATH (Month) Dec (Day) 1 (Year) 69

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Mar 17 1908
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintaince Foreman 08
10b. KIND OF BUSINESS OR INDUSTRY: Road District
11. BIRTHPLACE (State or foreign country): Troublesome, Colorado
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Grover T. Hackwith — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Myrtle Hendon — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 22 6483
17. INFORMANT'S OWN SIGNATURE: Thomas E. Hackwith — ADDRESS: Craigmont, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: imm

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Coronary Occlusion — imm
DUE TO (c) Arteriosclerotic H.D. — long

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-30, 1969, *to* 12-1, 1969 *that I last saw the deceased alive on* 12-1, 1969, *and that death occurred at* 6:30 *p m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas M.D. 874
23b. ADDRESS: 628 5th Ave.
23c. DATE SIGNED: 12-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burialn
24b. DATE: Dec 4 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memorial
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-9-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: Clifton Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5858
Local Reg. No. 307
Reg. Dist. No. 220

RECEIVED

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35 DEC 3 1969
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 626-Bryden Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Dora	S.	Lindsay	Dec. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		5-28-1886	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Randers, Denmark
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: No Record — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-01-0906
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Lewiston, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cancer of colon — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) congestive heart failure
pulmonary edema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* Dec. 1, 1969, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 1:30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Lewiston, Idaho	12-1-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Dec. 4, 1969	Twin Falls Cemetery	TwinFalls, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-1-69	Elnora Walzen	Andrew F. Vassar	E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5859
Local Reg. No. 304
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 15 1969 Bureau of Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35-1 Nez Perce
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington
b. COUNTY 48 Garfield 5-55
c. CITY OR TOWN Pomeroy
d. STREET ADDRESS (If rural, give location) Rural Rte.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital 128

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	VIVIAN	ALMA	SHERRILL	12	1	69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	3-17-1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward Laing — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary Richardson — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-18-9523
17. INFORMANT'S OWN SIGNATURE Lester Sherrill ADDRESS Lester Sherrill Pomeroy, Wn.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4319

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arth Sclerosis — 4 YRS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary Heart Disease — 4 YRS

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1969 *to* Dec 1, 1969, *that I last saw the deceased alive on* Dec 1, 1969, *and that death occurred at* 1:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
MD	307 1st Lewiston	12/5/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	12-5-1969	City	Pomeroy, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-8-69	Glenda Walzen	Andy Reinland, Jr.	QL-890

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 23 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5860
Local Reg. No. 316
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH — DEC 23 1969
a. COUNTY: Nez Perce (350)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston-rurla
c. LENGTH OF STAY (in this place): 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor Nursing H. (312)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho (13)
b. COUNTY: Clearwater (180)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Baxter; b. (Middle) DeWalt; c. (Last) Renshaw

4. DATE OF DEATH (Month) (Day) (Year): Dec. 2, 1969

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Dec. 4, 1879

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): painter (21)

10b. KIND OF BUSINESS OR INDUSTRY: decorating

11. BIRTHPLACE (State or foreign country): Colfax, Wash.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Renshaw — BIRTHPLACE: Mo.

14. MOTHER'S MAIDEN NAME: Ada Wolford — BIRTHPLACE: Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-18-8336

17. INFORMANT'S OWN SIGNATURE: Lyle Stallmann — ADDRESS: Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Auricular Fibrillation

INTERVAL BETWEEN ONSET AND DEATH: 5 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/29, 1969, *to* 12/2, 1969, *that I last saw the deceased alive on* 12/2, 1969, *and that death occurred at* 12:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. M. Stover (307) (Degree or title): M.D

23b. ADDRESS: 939 Bryden Lewiston, Idaho

23c. DATE SIGNED: 12/9/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 4, 69

24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery

24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: 12-16-69

REGISTRAR'S SIGNATURE: Glenna Dalzen

25. EMBALMER: Lyle Stallmann — LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5861
Local Reg. No. 305
Reg. Dist. No. 220

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nezperce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 303 North State

3. NAME OF DECEASED (Type or Print): a. (First) EARL b. (Middle) c. (Last) McHARGUE

4. DATE OF DEATH (Month) (Day) (Year): December 3, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Dec 13, 1904

9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (State or foreign country): Corbin, Kentucky

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Abijha McHargue — BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Sally Ohler — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-18-3811

17. INFORMANT'S OWN SIGNATURE: Robert McHargue II — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Myocardial infarction
DUE TO (c): Arteriosclerotic

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: heart Disease

INTERVAL BETWEEN ONSET AND DEATH: 3 da.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-1, 19 69, *to* 12-3, 19 69, *that I last saw the deceased alive on* 12-3, 19 69, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD — **23b. ADDRESS**: 678 5th Ave Lewiston Idaho — **23c. DATE SIGNED**: 12/8/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: Dec 6, 1969

24c. NAME OF CEMETERY OR CREMATORY: Prairieview

24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: 12-8-69

REGISTRAR'S SIGNATURE: Glenora Wolgen

25. EMBALMER: Robert R Hansen — **LICENSE NO.**: E433

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 24 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5862
Local Reg. No. 311
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 15 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 417 - 28th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): EDWARD
c. (Last): BERGER

4. DATE OF DEATH (Month) (Day) (Year): 5 December 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 13 March 1901
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Stock & Grain
11. BIRTHPLACE (State or foreign country): Pittsburgh, Penna.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Berger — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Mary Braun — BIRTHPLACE: Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 42 2713 A
17. INFORMANT'S OWN SIGNATURE: Irene Berger — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1990

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Metastatic Carcinoma — 11 months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-28, 1969 *to* 12-5, 1969, *that I last saw the deceased alive on* 12-4, 1969, *and that death occurred at* 1:02 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John F. Barnes 028 M.D.
23b. ADDRESS: 307 St Johns Way Lewiston, Idaho
23c. DATE SIGNED: 12-6-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal/Burial 3
24b. DATE: 8 Dec 1969
24c. NAME OF CEMETERY OR CREMATORY: Genesee City Cemetery
24d. LOCATION (City, town, or county) (State): Genesee, Idaho

DATE REC'D BY LOCAL REG.: 12-12-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: W E Black — LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 16 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 24 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 5863
Local Reg. No. 313
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 — DEC 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston — Bureau of Vital Statistics — LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 823 Preston Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BENJAMIN	FREDRICK	BUCHHOLZ	5 December 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	8 March 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rural Carrier 08	U. S. Postal Dept.	Onida, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John B. Buchholz	Minnesota	Elizabeth Keller	Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW-I	519 44 5634	Mrs. Vernice Buchholz	Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral (artery) thrombosis. — ONSET AND DEATH: 4 days.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March, 1966, *to* 5 Dec., 19 69, *that I last saw the deceased alive on* 5 Dec., 1969, *and that death occurred at* 11:50 AM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B R Stein 446 MD	Lewiston Idaho	12 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	8 Dec 1969	Vineland Cemetery	Clarkston, Asotin Co., Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-16-69	Elenard Walgen	W E Black	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5864
Local Reg. No. 307
Reg. Dist. No. 220

BIRTH REC

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Garfield 533
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pomeroy
d. STREET ADDRESS (If rural, give location): 136 - 7th Street

3. NAME OF DECEASED (Type or Print): a. (First) FLOYD; b. (Middle) BENJAMIN; c. (Last) KAUSCHE

4. DATE OF DEATH: (Month) 12 (Day) 5 (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2-5-1906

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Wheat Farm

11. BIRTHPLACE (State or foreign country): Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Kausche
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Odessa Trosper
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-40-8342

17. INFORMANT'S OWN SIGNATURE: Mrs. Margaret Krusche
ADDRESS: Pomeroy, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible]
INTERVAL BETWEEN ONSET AND DEATH: 1 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) [illegible]
INTERVAL BETWEEN ONSET AND DEATH: 7 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

492X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 11, 1967, *to* Dec. 5, 1969, *that I last saw the deceased alive on* Dec. 5, 1969, *and that death occurred at* 10:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) D.O.

23b. ADDRESS: 625 6th Ave., Lewiston, Ida.

23c. DATE SIGNED: 12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial

24b. DATE: 12-8-69

24c. NAME OF CEMETERY OR CREMATORY: City

24d. LOCATION (City, town, or county) (State): Pomeroy, Washington

DATE REC'D BY LOCAL REG.: 12-11-69

REGISTRAR'S SIGNATURE: Glenda Dalzen

25. EMBALMER: Andy Steinland, Jr.

LICENSE NO.: QL-890

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 6 1970

JUL 17 1984

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5865
Local Reg. No. 312
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nezperce 351
DEC 23 1969
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
DURATION OF STAY (in this place): hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nezperce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1040 Warner

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	James	William	Crew	Dec.	6	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
male	white	divorced	June 14, 1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 06		Reubens Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James William Crew	Mo.	Cordelia Mallen	Abilene, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW2 4	519 12 4249	Roy Crew	Reubens, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Methyl Alcohol Poisoning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

860X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		Lewiston	Nez Perce	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
	?		m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	

22. *I hereby certify that I attended the deceased from* 12 6, 1969, *to* 12 6, 1969, *that I last saw the deceased alive on* 12 6, 1969, *and that death occurred at* 5 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. Cummins	M.D.	347 D Solwise Lebey Lewiston	12 9 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	December 11 69	Community	Reubens	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-15-69	Glenna Dalzen	Albert Uhlorn	E 421

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5866
Local Reg. No. 313
Reg. Dist. No. 220

RECEIVED DEC 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 324 20th St. N.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1124 Idaho Street

3. NAME OF DECEASED (Type or Print) a. (First) Raymond b. (Middle) Knut c. (Last) Sletager

4. DATE OF DEATH (Month) Dec. (Day) 9 (Year) 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH May 8, 1922

9. AGE (In years last birthday) 47 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawmill worker

10b. KIND OF BUSINESS OR INDUSTRY Lumbering

11. BIRTHPLACE (State or foreign country) Sandpoint, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ole Sletager
BIRTHPLACE Minnesota

14. MOTHER'S MAIDEN NAME Augusta Johansson
BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 2 4

16. SOCIAL SECURITY NO. 519 18 2124

17. INFORMANT'S OWN SIGNATURE Mrs Ole Sletager ADDRESS Sandpoint, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock and Hemhorrage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Massive Skull Fracture — unk.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 32 tavern basement

21c. (CITY, TOWN, OR TOWNSHIP) Lewiston 1335 (COUNTY) NezPerce (STATE) Idaho

21d. TIME OF INJURY (Month) 12/8/69 (Day) (Year) (Hour) 9:45PM m.

21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR? fall down stairway

22. I hereby certify that I attended the deceased from 666 ____, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at see reverse hr., from the causes and on the date stated above.

23a. SIGNATURE [signature] 583 (Degree or title) Coroner

23b. ADDRESS Lewiston, Idaho

23c. DATE SIGNED 12/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3

24b. DATE 12/10/69

24c. NAME OF CEMETERY OR CREMATORY Sandpoint, Idaho

24d. LOCATION (City, town, or county) Sandpoint, Idaho (State)

DATE REC'D BY LOCAL REG. 12-16-69

REGISTRAR'S SIGNATURE Glenara Dalzell

25. EMBALMER D. Vassar

LICENSE NO. E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 23 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 24 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 5 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 10 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician: The victim was last seen at the club 12/6/69 It is believed that he went into a rear room and to the stairway and ~~was~~ fell down the stairs and died the night of the 6th or in the early hours of the 7th. Time of death on reverse this reoprt was listed at time of arrival of coroner.

Certificate of Death

STATE OF IDAHO

State File No. 5867
Local Reg. No. 320
Reg. Dist. No. 320

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 351 DEC 29 1969
b. CITY OR TOWN Lewiston
LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1801 - Burrell Ave.

3. NAME OF DECEASED (Type or Print) a. (First) JUNIOR b. (Middle) LEE c. (Last) STUBBLEFIELD

4. DATE OF DEATH (Month) (Day) (Year) 9 December 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH 22 January 1923
9. AGE (In years last birthday) 46 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman 17
10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill
11. BIRTHPLACE (State or foreign country) Grangeville, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Newell Stubblefield BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Emma Aliceson BIRTHPLACE St Louis, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not preknown) YES (If yes, give war or dates of service) WW-2 (Navy) H
16. SOCIAL SECURITY NO. 518 20 0862
17. INFORMANT'S OWN SIGNATURE Norman D. Lupe ADDRESS Clarkston, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4189

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 3 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14 1966, *to* 9-30, 1969, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 7:30 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 083 John E. Casson
23b. ADDRESS 9th & Main Lewiston Ida
23c. DATE SIGNED 12-20-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12 Dec. 1969
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-26-69
REGISTRAR'S SIGNATURE Mona Walzer
25. EMBALMER W E Black
LICENSE NO. E-426
FIRM NAME: Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Seen by Dr. Rogers at time of death

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 23 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5868
Local Reg. No. 3174
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1103- Prospect Ave

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Malcolm	J.	McRae	Dec 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct, 3, 1904	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Physician 14
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NezPerce, Idaho.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: B.J. McRae — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Mary C. Dempsey — BIRTHPLACE: Hasting, Ness, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 514-54-0113I
17. INFORMANT'S OWN SIGNATURE: Eugenia D McRae — ADDRESS: Lewiston, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Digitalis Intoxication~~

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 4+ years
DUE TO (c) generalized Arteriosclerosis — 4+ years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Digitalis Intoxication. — 2+ days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 Dec., 1969, *to* 12 Dec., 1969, *that I last saw the deceased alive on* 12 Dec., 1969, *and that death occurred at* 5 20 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Lewiston Idaho	15 Dec. 69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 15, 1969	Normal Hill Cemetery	Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 12-16-69
REGISTRAR'S SIGNATURE: Geneva Dalzen
25. EMBALMER: Andrew F. Vassar — LICENSE NO.: E 315
FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 24 1969

AUG 18 2009

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5869
Local Reg. No. 318
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

DEC 29 1969

1. PLACE OF DEATH
a. COUNTY 351 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (If in this place) 18days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 323-Adams St

3. NAME OF DECEASED (Type or Print)
a. (First) Aura
b. (Middle)
c. (Last) Bonham

4. DATE OF DEATH (Month) (Day) (Year) Dec, 13, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 4-23-85
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 04 Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Newton, Kansasa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Landon Bonham — BIRTHPLACE Ky
14. MOTHER'S MAIDEN NAME Mary Morgan — BIRTHPLACE Ky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-18-3402A
17. INFORMANT'S OWN SIGNATURE X Florence Cape — ADDRESS Lewiston, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

517X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary fibrosis — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1967, *to* Dec, 1969, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Richard M. Alford M.D. 194
23b. ADDRESS 1522-17th St. Lewiston Ida
23c. DATE SIGNED 12-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-17-69
24c. NAME OF CEMETERY OR CREMATORY Normal Hill
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG. 12-22-69
REGISTRAR'S SIGNATURE Glenara Dalzen
25. EMBALMER Andrew F. Vassar — LICENSE NO. E315
FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5870
Local Reg. No. 319
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 — DEC 29 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston — Bureau of Vital Statistics
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3318 - 9th Street

3. NAME OF DECEASED (Type or Print)
a. (First): EMMA
b. (Middle): MARGARET
c. (Last): BUTLER

4. DATE OF DEATH (Month) (Day) (Year): 13 December 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 13 April 1891
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Peter McDermott — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Charolet Tickler — BIRTHPLACE: Penna.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 538 26 6001B
17. INFORMANT'S OWN SIGNATURE: Marion W Tittle — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2315

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Malnutrition — 1 yr.
DUE TO (c): Mediastinal Mass. — 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-16, 1967 *to* 12-12, 1969, *that I last saw the deceased alive on* 12-12, 1969, *and that death occurred at* 10:35 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 020
23b. ADDRESS: 625 Sixth Ave., Lewiston
23c. DATE SIGNED: 12-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal/Burial
24b. DATE: Burial 17 Dec 1969
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Asotin Co., Wn.

DATE REC'D BY LOCAL REG.: 12-23-69
REGISTRAR'S SIGNATURE: Glenara Walzer
25. EMBALMER: W. E. Black — W E Black — LICENSE NO. #-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5871
Local Reg. No. 323
Reg. Dist. No. 220

BIRTH NO.

RECEIVED
JAN 6 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Nez Perce 35
b. CITY OR TOWN Lewiston
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Jos4ph's 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 4th & D Streets

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Willy	Frank	Cucas	Dec. 13, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white		Jan. 19, 1888	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
carpenter 21	self	Brockhead, New York	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Francie Willy Cucas	no record	no record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519 09 1039	[signature]	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3039

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia - possible C.V.A. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis - C

DUE TO (c) Dehydration & advanced

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Vascular disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/13 69, 19__, *to* 12/13/69, 19__, *that I last saw the deceased alive on* 12/13/69 19__, *and that death occurred at* 9:50P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	036	626 5th Ave. Lewiston, Idaho	12/20/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 16, 1969	Normal Hill cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-30-69	[signature]	V. Vassar	E 297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED IDAHO

State File No. 5872
Local Reg. No. 322
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 NezPerce DEC 29 1969
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY IN HOSPITAL OR INSTITUTION
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1826 Grelle

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Milton
b. (Middle)
c. (Last) Meuli

4. DATE OF DEATH (Month) (Day) (Year) Dec 17, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 8-191887
9. AGE (In years last birthday) 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 28
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Uniontown, Wash.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Martin Meuli
BIRTHPLACE

14. MOTHER'S MAIDEN NAME no record
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-22-4747

17. INFORMANT'S OWN SIGNATURE Dorothea E Mitchell ADDRESS Portland, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1 Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 2 Cardiac Decompensation
DUE TO (c) 3 Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 4 Chronic Cystitis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-28-66, 19___, *to* 11-16, 1969, *that I last saw the deceased alive on* 11-16, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Don Stover (Degree or title) 507
23b. ADDRESS 939 Bryden Ave. Lew.
23c. DATE SIGNED 12-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Dec. 19. 1969
24c. NAME OF CEMETERY OR CREMATORY Comunity Cemetery
24d. LOCATION (City, town, or county) (State) Uniontown, Wash.

DATE REC'D BY LOCAL REG. 12-26-69
REGISTRAR'S SIGNATURE Glenora Dalzen
25. EMBALMER V. Vasser
LICENSE NO. E 297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5873
Local Reg. No. 317
Reg. Dist. No. 220

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
c. LENGTH OF STAY (in this place): 11 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPHS HOSPITAL 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: NEZ PERCE 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEWISTON
d. STREET ADDRESS (If rural, give location): 3428 9th

3. NAME OF DECEASED (Type or Print): a. (First) INEZ b. (Middle) NOLEN c. (Last) TOWNSEND

4. DATE OF DEATH: (Month) DEC. (Day) 17 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 12, 1897

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): Baker, Oregon

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James R. Nolen — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: (NFI) Rossen — BIRTHPLACE: Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-18-9071

17. INFORMANT'S OWN SIGNATURE: John B Townsend — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cancer of Cervix
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

180X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, *1969, to* Dec 17, *1969, that I last saw the deceased alive on* June 16, *1969, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 051 — (Degree or title): MD

23b. ADDRESS: 1522 17th St Lewiston, Idaho

23c. DATE SIGNED: Dec. 18, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Dec. 19, 1969

24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery

24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 12-18-69

REGISTRAR'S SIGNATURE: Elenara Dalzen

25. EMBALMER: W C Merchant — LICENSE NO.: FD 5

FIRM NAME: Merchant Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5874
Local Reg. No. 324
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 6 1970 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 718-15th Avenue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 718 15th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Kenneth
b. (Middle): B.
c. (Last): Stone

4. DATE OF DEATH (Month) (Day) (Year): Dec. 21, 1969

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Dec. 5, 1916
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Room Mgr. 26
10b. KIND OF BUSINESS OR INDUSTRY: retail Drygoods
11. BIRTHPLACE (State or foreign country): Spencer, Iowa
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: morris Stone — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 482 01 4114
17. INFORMANT'S OWN SIGNATURE: Dorothy M. Stone — ADDRESS: Lewiston, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-21, 1969, *to* 12-21-, 1969, *that I last saw the deceased alive on* 12-21-, 1969, *and that death occurred at* 2:30p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 502 D. Stige M.D.
23b. ADDRESS: 307 St. John's Way, Lewiston, Idaho
23c. DATE SIGNED: 12/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 12/24/69
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-30-69
REGISTRAR'S SIGNATURE: Glenara Walzen
25. EMBALMER: V. Vassar
LICENSE NO.: E 297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 14 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 28 1981

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

JAN 18 1971

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics JAN 7 1970

State File No. 5875
Local Reg. No. 2
Reg. Dist. No. 240

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nezperce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 2 hr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hosp 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Grangeville, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) ALLEN b. (Middle) LeRoy c. (Last) DENNEY

4. DATE OF DEATH (Month) (Day) (Year): December 22, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 30, 1918

9. AGE (In years last birthday): 51
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 21

10b. KIND OF BUSINESS OR INDUSTRY: Farming & Mechanic

11. BIRTHPLACE (State or foreign country): Reubens, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alva LeRoy Denney — BIRTHPLACE: Lincoln Co. Wash

14. MOTHER'S MAIDEN NAME: Phoebe Bonnalie — BIRTHPLACE: Nezperce Co. Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW #2 4

16. SOCIAL SECURITY NO.: 516 03 9272

17. INFORMANT'S OWN SIGNATURE: Shirley Denney jr — ADDRESS: Reubens, Ida.

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Major Motor Seizures

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): 2° to Obstructive Lung Dis.
DUE TO (c): & Cardiac Arrest.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death*: Chron. Alcoholism

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 24, 1965, *to* Dec. 22, 1969, *that I last saw the deceased alive on* Dec. 22, 1969, *and that death occurred at* 6:25A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton H. Walter M.D.

23b. ADDRESS

23c. DATE SIGNED: 29 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 3

24b. DATE: 12/23/69

24c. NAME OF CEMETERY OR CREMATORY: Prairieview

24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Jan. 3 1970

REGISTRAR'S SIGNATURE: Dana Cone

25. EMBALMER: Robert R Hansen — Robert R Hansen

LICENSE NO.: E 435

FIRM NAME: Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JAN 6 1970
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5876
Local Reg. No. 327
Reg. Dist. No. 320

BIRTH

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	A.	Paffile	Dec. 22. 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	2-17-1876	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME — BIRTHPLACE
14. MOTHER'S MAIDEN NAME — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: x Mary Paffile — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4-1-69

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 2) Pneumonia
DUE TO (c) 3) Infirmities of age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 - 19, 1968, *to* 12 - 22, 1969, *that I last saw the deceased alive on* 12 - 22, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Don Flower MD
23b. ADDRESS: 939 Bryden Ave
23c. DATE SIGNED: 12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 12-30-69
REGISTRAR'S SIGNATURE: Glenara Dalzell
25. EMBALMER: Andrew F. Vassar
LICENSE NO.: E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5877
Local Reg. No. 321
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 29 1969 Bureau of Vital Stat. Sec.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 8 Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Southwick
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): CHLOE
b. (Middle): ESSEL
c. (Last): TRIPLETT

4. DATE OF DEATH (Month) (Day) (Year): 22 December 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 28 Sept. 1884
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Elzie Phillips — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Alice Zinn — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 05 2587-B
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Southwick, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1990

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Ca. Source Unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-26, 1969, *to* 12-22, 1969, *that I last saw the deceased alive on* 12-15, 1969, *and that death occurred at* 5:30AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 114.
23b. ADDRESS: 347 S. Johns Way
23c. DATE SIGNED: 12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 26 Dec 1969
24c. NAME OF CEMETERY OR CREMATORY: Southwick, Cemetery
24d. LOCATION (City, town, or county) (State): Southwick, Idaho

DATE REC'D BY LOCAL REG.: 12-24-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: W E Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5878
Local Reg. No. 323
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 6 1970 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 222 - Glassway

3. NAME OF DECEASED (Type or Print)
a. (First): Craige
b. (Middle): Lambert
c. (Last): Embree

4. DATE OF DEATH (Month) (Day) (Year): December 24, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 31, 1899
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior designer 21
10b. KIND OF BUSINESS OR INDUSTRY: shoe store
11. BIRTHPLACE (State or foreign country): Atalissa, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Embree — BIRTHPLACE: Atalissa, Iowa
14. MOTHER'S MAIDEN NAME: Elizabeth Lambert — BIRTHPLACE: Atalissa, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No Record
16. SOCIAL SECURITY NO.: 164-07-0157
17. INFORMANT'S OWN SIGNATURE: Naomi E Stevens — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion c̄ myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): ASHD — long duration
DUE TO (c): Generalized A.S. — long duration

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-23, 1969 *to* 12-24, 1969, *that I last saw the deceased alive on* 12/23, 1969, *and that death occurred at* 12:30 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas Moe 874
23b. ADDRESS: 628 5th Ave Lewiston
23c. DATE SIGNED: 12/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Dec. 26, 1969
24c. NAME OF CEMETERY OR CREMATORY: Arizonia Mortuary
24d. LOCATION (City, town, or county) (State): Tucson, Arizonz (Pima Co.)

DATE REC'D BY LOCAL REG.: 1-5-70
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: L.E. DeBaun — LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5879
Local Reg. No. 326
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: NEZ PERCE 351
b. CITY OR TOWN: LEWISTON
c. DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPHS HOSPITAL 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: WASHINGTON 48
b. COUNTY: PEND OREILLE 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NEWPORT
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) ARTHUR b. (Middle) (NMI) c. (Last) FISHER

4. DATE OF DEATH: (Month) Dec. (Day) 26, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 5, 1906

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24

10b. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (State or foreign country): Washington

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Thomas Fisher
BIRTHPLACE: Wisconsin

14. MOTHER'S MAIDEN NAME: Cora Phelps
BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ~~N~~
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 532-10-4142

17. INFORMANT'S OWN SIGNATURE: Keith Bruckenberg ADDRESS: Lew. Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4410

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 10 min ±

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Tamponade — 10 min ±
DUE TO (c) Dissecting Aneurysm of aorta — 10 ± minutes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 26 Dec, 1969, *to* 26 Dec., 1969, *that I last saw the deceased alive on* 26 Dec., 1969, *and that death occurred at* 8:37 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 446 (Degree or title) MD
23b. ADDRESS: 307 St. Johns Way Lewiston, Ida.
23c. DATE SIGNED: 29 Dec 69

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3
24b. DATE: Dec 27, 1969
24c. NAME OF CEMETERY OR CREMATORY: Newport Cemetery
24d. LOCATION (City, town, or county) (State): Newport Washington

DATE REC'D BY LOCAL REG.: 12-30-69
REGISTRAR'S SIGNATURE: Alvara Walgen
25. EMBALMER: W.C. Merchant
LICENSE NO.: FD 5
FIRM NAME: Merchant Funeral Home Clk. Wash.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 20 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5880
Local Reg. No. 328
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JAN 6 1970 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN: Lewiston
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 631-4th Ave

3. NAME OF DECEASED (Type or Print): a. (First) Gregory; b. (Middle); c. (Last) Eaves

4. DATE OF DEATH: (Month) Dec. (Day) 28th (Year) 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan, 29, 1896

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 28

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lewiston, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Elliott E. Eaves
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Julia Gregory
BIRTHPLACE: Mich.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): W.W.I
(If yes, give war or dates of service): 3

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: X Ruth G. H. Eaves
ADDRESS: Lewiston, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4419

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Aneurism Rupture.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12 24, 1969, *to* 12 28, 1969, *that I last saw the deceased alive on* 12 28, 1969 *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 114.

23b. ADDRESS:

23c. DATE SIGNED: 12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec 31, 1969

24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 12-30-69

REGISTRAR'S SIGNATURE: Elenara Walzer

25. EMBALMER: V. Vassar

LICENSE NO.: E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5881
Local Reg. No. 1
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
JAN 19 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3122 - 6th Street

3. NAME OF DECEASED (Type or Print)
a. (First): EDNA
b. (Middle): PEARL
c. (Last): MOATS

4. DATE OF DEATH (Month) (Day) (Year): 28 December 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 25 August 1897
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Granton, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Edwards — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Emma Strong — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ~~542-24-1256D~~ 1420 518 50 2184
17. INFORMANT'S OWN SIGNATURE: Raymond E. Moats — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca Mex Ed Tumor of Parotid gland — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Metastasis to colon — 18 mo.
DUE TO (c) obstruction of colon — 3 mo.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 1965
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Parotid gland
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1954, *to* Dec 28, 1969, *that I last saw the deceased alive on* Dec 28, 1969, *and that death occurred at* 12:45 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph E. Boeckh, M.D. 022
23b. ADDRESS: 1022 17th St Lewiston Idaho
23c. DATE SIGNED: 12-30/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 30 Dec 1969
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 1-7-70
REGISTRAR'S SIGNATURE: Glenara Dalzen
25. EMBALMER: W E Black — W E Black
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 29 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5882
Local Reg. No. 22
Reg. Dist. No. 530

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Oneida 36
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City
c. LENGTH OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oneida Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Oneida 36
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Gwenford (Samaria)
d. STREET ADDRESS (If rural, give location): RFD # 1, Malad, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) EMMA; b. (Middle) PRICE; c. (Last) WALDRON

4. DATE OF DEATH (Month) (Day) (Year): December 16, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: April 10, 1906

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife o.

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Samaria, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Evan Price
BIRTHPLACE: Wales

14. MOTHER'S MAIDEN NAME: Emma Morse
BIRTHPLACE: Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-68-9041

17. INFORMANT'S OWN SIGNATURE: x L. R. Waldron
ADDRESS: Gwenford, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 398X Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Long standing Rheumatic heart disease
DUE TO (c): 2 general surgeries in 1 week

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic & Acute Cholecystitis & liver failure

19a. DATE OF OPERATION: 12-16-69

19b. MAJOR FINDINGS OF OPERATION: Generalized Intra tissue Bleeding abdominal wall

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 4, 1969, *to* Dec 16, 1969 *that I last saw the deceased alive on* Dec 16, 1969, *and that death occurred at* 9:28 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John A. Jones M.D.

23b. ADDRESS: Malad City, Idaho

23c. DATE SIGNED: 12/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 20 Dec 1969

24c. NAME OF CEMETERY OR CREMATORY: Samaria City Cemetery

24d. LOCATION (City, town, or county) (State): Samaria, Oneida, Idaho

DATE REC'D BY LOCAL REG.: 12/19/69

REGISTRAR'S SIGNATURE: Ruth D. Newton

25. EMBALMER: Raiford G. Benson
LICENSE NO.: E-351

FIRM NAME: Benson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 27 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 18 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 21 1987

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 21 1970 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5883
Local Reg. No. 23
Reg. Dist. No. 530

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Oneida 36
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City
LENGTH OF STAY (in this place): 29 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oneida County Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Oneida 36
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City
d. STREET ADDRESS (If rural, give location): 231 N. Main St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ANNIE	THOMAS	VANDERWOOD	DEC.	28	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	13 Oct 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	--	Malad City, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
BENJAMIN L. THOMAS	Brigham City, Utah	ELIZABETH EVANS	Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	--	519-44-6238	Howard Vanderwood	Malad, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5400

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Surgery — 1 month
DUE TO (c) Stroke - R hemiparesis — " "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Post operative 1 month - appendicitis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Ruptured Appendix	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 1, 1969, *to* Dec. 28, 19 69, *that I last saw the deceased alive on* Dec 28, 1969, *and that death occurred at* 8:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John A Jones M.D.	Malad City, Idaho	30 Dec 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	31 Dec 1969	Malad City Cemetery	Malad, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
30 Dec 1969	Ruth G. Sweeten	Raiford G. Benson	E-351

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 8 1969 Bureau of Vital Statistics

State File No. 5884
Local Reg. No. 258
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
LENGTH OF STAY (In this place) 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2026 Center Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Helen	Hedvig	Calkins	Dec.	2	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	11-4-1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	Oak Park, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Martin Gunther	Germany	Anna Mollie Ziegler	Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	MA-931491	William Calkins Jr.	Payette

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4423

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Dis. — 2 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov. 20, 1969, *to* Dec. 2, 1969, *that I last saw the deceased alive on* Nov. 28, 1969, *and that death occurred at* 9:15a. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. Hoagland, M.D. 082	Payette, Idaho	12/4/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/5/69	Rosedale Memorial Gdns	Payette Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-4-69	Muriel Anderson	Donald F. Brown	E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5885
Local Reg. No. 160
Reg. Dist. No. 330

BIRTH NO.

RECEIVED DEC 24 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 3½ years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Casa Loma Conv. Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1515 N. 14th

3. NAME OF DECEASED (Type or Print)
a. (First) Margaret
b. (Middle) H.
c. (Last) McVety

4. DATE OF DEATH (Month) (Day) (Year) December 11, 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH September 8, 1875
9. AGE (In years last birthday) 94 — IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) New Richmond, Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Quinlan Haines
BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Mary J. Goble
BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) — — —
16. SOCIAL SECURITY NO. 519-64-4797
17. INFORMANT'S OWN SIGNATURE Dorothy M. Wendel
ADDRESS Yokuska, Japan

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1964, *to* Dec 11, 1969, *that I last saw the deceased alive on* Nov 29, 19 69, *and that death occurred at* 3:00P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Thomas W. Wade Jr. M.D
23b. ADDRESS Payette Idaho
23c. DATE SIGNED 12/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 15, 1969
24c. NAME OF CEMETERY OR CREMATORY Park View
24d. LOCATION (City, town, or county) New Plymouth (State) Idaho

DATE REC'D BY LOCAL REG. 12-22-69
REGISTRAR'S SIGNATURE Annabel Anderson
25. EMBALMER Keith W. Jensen
LICENSE NO. E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 2 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5886
Local Reg. No. 159
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
c. LENGTH OF STAY (in this place): 35 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grand Motel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
d. STREET ADDRESS (If rural, give location): Grand Motel

3. NAME OF DECEASED (Type or Print)
a. (First): Otto
b. (Middle): Walter
c. (Last): Schlutow

4. DATE OF DEATH (Month) (Day) (Year): Dec. 15 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Oct 3 1896
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW11 4
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: X Wm Ray Reeves — ADDRESS: Fruitland Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arterial Sclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* ~~attended the deceased from~~ Investigated, ~~19~~, *to* On Dec 16 1969, ~~that I last saw the deceased alive on~~ ~~19~~, *and that death occurred at* 10:00 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE: Hardy Harkom 583 (Degree or title): Payette Co. Coronor
23b. ADDRESS: 112½ N 8th
23c. DATE SIGNED: 12-17-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial Removal
24b. DATE: 12-19-69
24c. NAME OF CEMETERY OR CREMATORY: Williamette National
24d. LOCATION (City, town, or county) (State): Portland Multnomah Oregon

DATE REC'D BY LOCAL REG.: 12-18-69
REGISTRAR'S SIGNATURE: Annabel Anderson
25. EMBALMER: Donald F Brown
LICENSE NO.: E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 24 1969
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5887
Local Reg. No. 161
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 11 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1116 2nd Ave. South

3. NAME OF DECEASED (Type or Print)
a. (First): ADA
b. (Middle): MAY
c. (Last): LANGDON

4. DATE OF DEATH (Month) (Day) (Year): December 17, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: February 4, 1877
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hotel Manager 26
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Frazier — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Elizabeth Scott — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 542-18-1168
17. INFORMANT'S OWN SIGNATURE: Lottie L Bushnell — ADDRESS: LaGrande, Oregon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): ASHD and heart block — years
DUE TO (c): Senility — years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: pneumonitis — 2 weeks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan., 1958, *to* Dec. 17, 1969, *that I last saw the deceased alive on* Dec. 12, 1969, *and that death occurred at* 12:20 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 574
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-20-1969
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: 12-23-69
REGISTRAR'S SIGNATURE: Annabel Anderson
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer-Jensen Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5888
Local Reg. No. 162
Reg. Dist. No. 330

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Payette 350 — DEC 24 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
LENGTH OF RESIDENCE (At place of death): 3½ Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casa Loma Convalescent Center 355

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho — b. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1419 1st. Ave. South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Albert	Sidney	HOBBS	December 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	April 29, 1878	91	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clothing Merchant 22	Retail Clothing	Lowell, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James H. Hobbs	Kentucky	Annie Abbott	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	--	519-07-7204	Keith M. Jensen	Hospital Records

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 1959, 19__, *to* December 18, 1969, *that I last saw the deceased alive on* 12/13/, 19 69, *and that death occurred at* 7:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas W. Wade Jr.	M.D.	Payette, Idaho	12/19/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	12-22-1969	Rosedale	Payette	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-23-69	Kenneth Anderson	Keith M. Jensen	E-517

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5889
Local Reg. No. 163
Reg. Dist. No. 330

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Payette 380 JAN 6 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (In this place): 3 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION: Casa Loma Convalescent Center 353

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1158 8th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Gilbert		CREECH	December 25, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	November 16, 1911	58	- / -	- / -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	General Labor	Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Louis L. Creech	Unknown	Tillie Fent	Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - -	518-14-3656	Clyde W. Creech	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Chronic Cor Pulmonale 492X	years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Severe emphysema	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1955, *to* December 25, 1969, *that I last saw the deceased alive on* December 24, 1969, *and that death occurred at* 4:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas W. Walker Jr	M.D.	Payette, Idaho	12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-29-1969	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-2-70	Arnold Anderson	Keith M. Jensen	E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5890
Local Reg. No. 164
Reg. Dist. No. 330

BIRTH NO.

JAN 7 1970

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Payette 380	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Payette 380
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette c. LENGTH OF STAY (In this place): Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 645 N. 6th St. 000	d. STREET ADDRESS (If rural, give location): 645 N. 6th St.

3. NAME OF DECEASED (Type or Print)	a. (First): Joseph	b. (Middle): Elmore	c. (Last): OLDHAM	4. DATE OF DEATH (Month) (Day) (Year): December 30, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Sept. 9, 1883	9. AGE (In years last birthday): 86 — IF UNDER 1 YR. Months — Days — IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier 10	10b. KIND OF BUSINESS OR INDUSTRY: Railroad	11. BIRTHPLACE (State or foreign country): Newry, Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): — —	16. SOCIAL SECURITY NO.: 712-05-1122A	17. INFORMANT'S OWN SIGNATURE: Mary M. Staples	ADDRESS: Fruitland, Idaho	

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* ~~[illegible]~~ Investigated ~~[illegible]~~ *the deceased* ~~[illegible]~~ *on* Dec. 31, 1969, *and that death occurred at* Unk. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Hardy H Jackson 583 4	(Degree or title): Coroner	23b. ADDRESS: Payette, Idaho	23c. DATE SIGNED: 1-2-1970
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 1-3-1970	24c. NAME OF CEMETERY OR CREMATORY: Riverside	24d. LOCATION (City, town, or county): Payette (State): Idaho
DATE REC'D BY LOCAL REG.: 1-5-70	REGISTRAR'S SIGNATURE: [signature]	25. EMBALMER: Keith M. Jensen	LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 11 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5891
Local Reg. No. 23
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED DEC 12 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RR Crossing, 2 mi. West Am. Falls 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EMMA	LOUISE	SCHMIDTGALL	Dec. 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cauc.	Divorced	Jan. 21, 1936	33	10	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Station Attendant 06	Service Station	Heglar, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Floyd Batterton	Dayton, Wash.	Emma Abbott	Raft River, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-42-9253	Alfred Schmidtgall	Am. Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3109

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chest injuries — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile-train accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	RR Crossing, 2 mi. West. Am. Falls 06	3390 Power Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Dec. 5, 1969 4:05p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Automobile-train accident

22. *I hereby certify that I attended the deceased from* ~~XXXX

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5892
Local Reg. No. 24
Reg. Dist. No. 500-602

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

DEC 15 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls,
c. LENGTH OF CITY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location): 905 Falls Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): MADELINE
b. (Middle): L.
c. (Last): REED

4. DATE OF DEATH (Month) (Day) (Year): Dec. 9, 1969

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 19, 1889
9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months 11, Days 20
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Appleton, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Herman C. Bohm
BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Alvina Moser
BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-05-7308B
17. INFORMANT'S OWN SIGNATURE: Floyd R Reed
ADDRESS: Am. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 11 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Metastatic adenocarcinoma left breast — 10 mo.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: arteriosclerosis

19a. DATE OF OPERATION: 10-16-66
19b. MAJOR FINDINGS OF OPERATION: Adenocarcinoma left breast
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1960, *to* Dec. 9, 1969, *that I last saw the deceased alive on* Dec 9, 1969, *and that death occurred at* 11:59P m., *from the causes and on the date stated above.*

23a. SIGNATURE: F. C. Harris 203 (Degree or title) M.D.
23b. ADDRESS: 213 Idaho St. American Falls, Idaho 83211
23c. DATE SIGNED: 12-11-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-12-69
24c. NAME OF CEMETERY OR CREMATORY: Fallsview Cemetery
24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec 13, 1969
REGISTRAR'S SIGNATURE: Irene Deeg
25. EMBALMER: H. L. Davis
LICENSE NO.: E-253

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 25 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 23 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

RECEIVED DEC 23 1969 Bureau of Vital Statistics

State File No. 5893
Local Reg. No. 25
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Power 340	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: California 05 b. COUNTY: Imperial 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cafe, edge Am. Falls; c. LENGTH OF STAY (In this place): 20 min.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): El Centro, California 92243
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Cafe 000	d. STREET ADDRESS (If rural, give location): Rt 1 Box 91-A

3. NAME OF DECEASED (Type or Print) a. (First) ADRIAN	b. (Middle)	c. (Last) LAXAGUE	4. DATE OF DEATH (Month) (Day) (Year) Dec. 12. 1969	
5. SEX: Male	6. COLOR OR RACE: Cauc.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: Nov. 16, 1912	9. AGE (In years last birthday): 57; IF UNDER 1 YR. Months 0 Days 26; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shepherd 04	10b. KIND OF BUSINESS OR INDUSTRY: Sheep	11. BIRTHPLACE (State or foreign country): France	12. CITIZEN OF WHAT COUNTRY? U. S	
13. FATHER'S NAME: Jean Laxague	BIRTHPLACE: France	14. MOTHER'S MAIDEN NAME: Antionette Monling	BIRTHPLACE: France	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 11 yrs 8	16. SOCIAL SECURITY NO.: 560-52-0835	17. INFORMANT'S OWN SIGNATURE: Claire Rudeen	ADDRESS: Am. Falls, Idaho	

4319

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): American Falls, Power Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 12 1969, 19___, *to* Dec. 12, 1969, 19___, *that I last saw the deceased alive* dead *on* Dec. 12, 1969, 19___, *and that death occurred at* 1:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Bud Kelly 583 4 (Degree or title): Coronor	23b. ADDRESS: Am. Falls, Idaho	23c. DATE SIGNED: 12,13,69
24a. BURIAL, CREMATION, REMOVAL (Specify): Rem & Burial 3	24b. DATE: 12-13-69	24c. NAME OF CEMETERY OR CREMATORY: San Fernando Mission
24d. LOCATION (City, town, or county) (State): San Fernando, L.A. Calif.		
DATE REC'D BY LOCAL REG.: December 17, 1969	REGISTRAR'S SIGNATURE: Irene Deeg	25. EMBALMER: H. L. Davis H L Davis
LICENSE NO.: E-253		

FIRM NAME: DAVIS FURNITURE & MORTUARY INC.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Amended

Certificate of Death
STATE OF IDAHO

State File No. 5894
Local Reg. No. 26
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED Bureau of Vital Statistics JAN 8 1970

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Power 390	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho 13 b. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls LENGTH OF STAY (In this place): 9 days	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION: Power County Hospital 137	d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First): Rena	b. (Middle):	c. (Last): Schmidtgall	4. DATE OF DEATH (Month) (Day) (Year): December 14, 1969			
5. SEX: Female	6. COLOR OR RACE: Cauc.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: Nov. 7, 1962	9. AGE (In years last birthday): 7	IF UNDER 1 YR. Months: 1 Days: 7	IF UNDER 24 HRS. Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03	10b. KIND OF BUSINESS OR INDUSTRY: Grade School	11. BIRTHPLACE (State or foreign country): American Falls, Idaho	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Alfred Schmidtgall	BIRTHPLACE: Aberdeen, Ida.	14. MOTHER'S MAIDEN NAME: Emma Louise Batterton	BIRTHPLACE: Heglar, Ida.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT'S OWN SIGNATURE: Alfred Schmidtgall	ADDRESS: American Falls, Ida.			

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Respiratory arrest	½ hour
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Severe brain damage & skull fracture	9 days
DUE TO (c)	Auto-train accident	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Patient never regained consciousness	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Auto train accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): (fish hatchery road)	21c. (CITY, TOWN, OR TOWNSHIP): American Falls	(COUNTY) 13390 Power	(STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 5, 1969 - 4:05 p.m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?		

22. *I hereby certify that I attended the deceased from* Dec. 5, 19 69, *to* Dec 14, 19 69, *that I last saw the deceased alive on* December 14, 19 69, *and that death occurred at* 3:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 203	(Degree or title): M D	23b. ADDRESS: American Falls	23c. DATE SIGNED: Jan 6, 1970

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12-17-69	24c. NAME OF CEMETERY OR CREMATORY: Fallsview Cemetery	24d. LOCATION (City, town, or county): American Falls, Idaho	(State):
DATE REC'D BY LOCAL REG.: Dec. 19, 1969	REGISTRAR'S SIGNATURE: Irene Deeg	25. EMBALMER: H. L. Davis	LICENSE NO.: E-253	

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

DEC 23 1969

Bureau of Vital Statistics

State File No. 26
Local Reg. No.
Reg. Dist. No. 500-602

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Power
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (In this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Power
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) RENA; b. (Middle); c. (Last) SCHMIDTGALL

4. DATE OF DEATH: (Month) Dec. (Day) 14, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: Nov. 7, 1962

9. AGE (In years last birthday): 7
IF UNDER 1 YR. Months: 1 Days: 7
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: Grade school

11. BIRTHPLACE (State or foreign country): American Falls, Idaho

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Alfred Schmidtgall
BIRTHPLACE: Aberdeen, Ida.

14. MOTHER'S MAIDEN NAME: Emma Louise Batterton
BIRTHPLACE: Heglar, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Alfred Schmidtgall
ADDRESS: Am. Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Severe brain damage & skull fracture — 9 days
DUE TO (c): Auto- train accident

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: Patient never regained consciousness

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Auto train accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): (fish hatchery road)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): American Falls Power Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 5 1969 4:05p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: auto accident
Patient jumped from car to avoid train

22. *I hereby certify that I attended the deceased from* Dec. 5, 1969, *to* Dec. 14, 1969, *that I last saw the deceased alive on* December 15 1969, *and that death occurred at* 3:15P m., *from the causes and on the date stated above.*

23a. SIGNATURE: F. L. Harris (Degree or Title): M Dr

23b. ADDRESS: American Falls, Idaho

23c. DATE SIGNED: 16 Dec. 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-17-69

24c. NAME OF CEMETERY OR CREMATORY: Fallsview Cemetery

24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: December 19, 1969

REGISTRAR'S SIGNATURE: Irene Deer

25. EMBALMER: H. L. Davis

LICENSE NO.: E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service FORM DH-63021

[redacted] JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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F. L. HARMS, M. D.
213 IDAHO STREET
AMERICAN FALLS, IDAHO 83211
TELEPHONE 226-2131

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

Bureau of Vital Statistics
Boise, Idaho

Re: Rena Schmidtgall
Certificate of death

Rena Schmidtgall's sister Robyn age 8 had stated that they were told to jump that Rena did not jump from the car.

Anna Belle Williams saw the accident. She said Rena Schmidtgall did not jump from the car.

Harry Batterton saw the accident and said Rena Schmidtgall did not jump from the car.

I erred in the history as told to me. Rena didnot jump from the car as recorded in No.21f.

Signed F. L. Harms M.D.

RECEIVED

JAN 2 1970

Bureau of Vital Statistics

F. L. HARMS, M.D.
213 IDAHO STREET
AMERICAN FALLS, IDAHO 83211
TELEPHONE 226-2131

Bureau of Vital Statistics
Boise, Idaho

Re: Rena Schmidtgall
Certificate of death

Rena Schmidtgall's sister Robyn age 8 had stated that they were told to jump that Rena did not jump from the car.

Anna Belle Williams saw the accident. She said Rena Schmidtgall did not jump from the car.

Harry Patterson saw the accident and said Rena Schmidtgall did not jump from the car.

I erred in the history as told to me. Rena did not jump from the car as recorded in No.21f.

Signed _____

Certificate of Death

STATE OF IDAHO

State File No. 5895
Local Reg. No. 27
Reg. Dist. No. 5700-602

BIRTH NO.

RECEIVED
JAN 5 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES; b. (Middle) G.; c. (Last) KING

4. DATE OF DEATH: (Month) Dec. (Day) 28, (Year) 1969

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 7, 1875

9. AGE (In years last birthday): 94
IF UNDER 1 YR. Months: 7 Days: 21
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard King
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Catherine Galloway
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-20-1109A

17. INFORMANT'S OWN SIGNATURE: Minnie Jenkins
ADDRESS: Aberdeen, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): 4109 Massive Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Chronic Myocarditis — 1 year
DUE TO (c): Arteriolarsclerosis — 15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-7-69, 19____, *to* 12-28-69, 19____, *that I last saw the deceased alive on* 12-27-69, 19____ *and that death occurred at* 5:00A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): F. L. Harris 303 M.D.

23b. ADDRESS: 213 Idaho Street, American Falls, Idaho

23c. DATE SIGNED: 12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial 3

24b. DATE: 12-31-69

24c. NAME OF CEMETERY OR CREMATORY: Aberdeen Cemetery

24d. LOCATION (City, town, or county) (State): Aberdeen, Idaho

DATE REC'D BY LOCAL REG.: January 2, 1970

REGISTRAR'S SIGNATURE: Irene Deeg

25. EMBALMER: H. L. Davis

LICENSE NO.: E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service FORM DH-63021

NOV 2 4 1971

MAR 1 5 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 24 1969
Bureau of Vital Statistics

State File No. 5896
Local Reg. No. 89
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Shoshone 401	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg — LENGTH OF STAY (In this place) D.O.A.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital 141	d. STREET ADDRESS (If rural, give location) 201 Emerald

3. NAME OF DECEASED (Type or Print)	a. (First) ANTON	b. (Middle) ---	c. (Last) RICHTER	4. DATE OF DEATH (Month) (Day) (Year) November 22, 1969
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 9, 1923	9. AGE (In years last birthday) 46 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman 07	10b. KIND OF BUSINESS OR INDUSTRY Mining	11. BIRTHPLACE (State or foreign country) North Dakota	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anton Richter	BIRTHPLACE North Dakota	14. MOTHER'S MAIDEN NAME Mary Feist	BIRTHPLACE North Dakota	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 4 (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War II	16. SOCIAL SECURITY NO. 516-22-6587	17. INFORMANT'S OWN SIGNATURE X Mrs. Anton Richter Jr.	ADDRESS Kellogg, Idaho	

4109

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Thrombosis of Right Main Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Arteriosclerosis — Few years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 11-22-, 1969, *to* 11-22, 1969, *that I last saw the deceased alive on* 11-22, 1969, *and that death occurred at* about 1:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE A. M. Peterson, M.D. +14 (Degree or title)	23b. ADDRESS Wallace, Idaho	23c. DATE SIGNED 12-18-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 26, 1969	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) Kellogg (State) Idaho
DATE REC'D BY LOCAL REG. 12/19/69	REGISTRAR'S SIGNATURE [signature]	25. EMBALMER Russell D. Michel	LICENSE NO. E-520

FIRM NAME: Cornell's Maisel Funeral Ch.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED DEC 11 1969 Bureau of Vital Statistics

State File No. 5897
Local Reg. No. 88
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 401
a. STATE Idaho
b. COUNTY Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 307 E. Portland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
KENNETH	L.	JOHNSON	Dec. 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	divorced	May 27, 1915	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mining 07	mining	Eagle, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert E. Johnson	Iowa	Gladys P. Allen	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-01-2149	X Oleta L. Johnson	Kellogg, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple Rib Fractures, Rt

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 06	unknown 00000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Nov 4 1969 ? m.		Auto accident

22. *I hereby certify that I attended the deceased from* Nov 4, 1969 *to* Dec 1, 1969, *that I last saw the deceased alive on* Dec 1, 1969, *and that death occurred at* 2:25a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
461 Orland Boorn MD	Kellogg Idaho	12/3/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 5, 1969	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-5-69	Joe Devine	Russell D. Mikel	E-520

FIRM NAME Cornell's Maisel Fun'l Chap.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED

State File No. 5898
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY Shoshone 400 DEC 11 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 400 a. STATE Idaho b. COUNTY Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Smelterville Bureau of Vital Statistics LENGTH OF STAY (In this place) 24 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Smelterville
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 706 Washington Street 500	d. STREET ADDRESS (If rural, give location) 706 Washington Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	GARY	BLAINE	MARTIN	December 1, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	never married	Aug. 8, 1945	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Laborer 06	Manufacturing	Kellogg, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lester H. Martin	Washington	Jeraldine VanVelking	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes Viet Nam 7	518-5296264	* Jeraldine Wilson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

955X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Gunshot Wound of Head — INTERVAL BETWEEN ONSET AND DEATH: 1 second

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP / (COUNTY) / (STATE)
2 Suicide	Home 31	Smelterville 1340 Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
12-1-69 about 3:25 p.m.		Shot himself

22. *I hereby certify that I attended the deceased from* 12-1- 1969 *to* 12-1- 1969 *that I last saw the deceased alive on* 12-1- 1969 *and that death occurred at* about 3:25 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson, M.D.	Wallace, Idaho	12-4-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/6/1969	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
		Russell D. Mikel	E-520

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME Cornell's Maisel Fun'l Chap

DEC 12 1969
JAN 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 3 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5899
Local Reg. No. 183
Reg. Dist. No. 140

Certificate of Death

RECEIVED
DEC 15 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace, Idaho
d. STREET ADDRESS (If rural, give location): 1 Hemlock Street

3. NAME OF DECEASED (Type or Print)
a. (First): Signe
b. (Middle): Elizabeth
c. (Last): Sanders

4. DATE OF DEATH (Month) 12 (Day) 1 (Year) 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 2-10-1909
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Richland, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unobtainable — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Buck Sanders — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular Failure secondary — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) to Emphysema, Severe, Intestinal
DUE TO (c) Obstruction, Gastro-Intestinal

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hemorrhage, Cirrhosis of Liver & Influenza

492X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-30-, 1969, *to* 12-1, 1969, *that I last saw the deceased alive on* 12-1, 1969, *and that death occurred at* 8:00 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: G. M. Peterson, M.D. 414 (Degree or title)
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-6-1969
24c. NAME OF CEMETERY OR CREMATORY: Osburn Cemetery
24d. LOCATION (City, town, or county): Osburn (State): Idaho

DATE REC'D BY LOCAL REG.: 12-11-69
REGISTRAR'S SIGNATURE: Dale Cornell
25. EMBALMER: Derrell Juelfs
LICENSE NO.: E-518

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 12 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5900
Local Reg. No. 126
Reg. Dist. No. 140

BIRTH NO.

RECEIVED
DEC 24 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hosp. 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
d. STREET ADDRESS (If rural, give location) Box 134

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Frederick	Nicholas	Hofmann		12	12	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Jan. 26, 1912	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ball Mill Operator	Minning	Clear Lake, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Anton Hofmann	Unknown	Mary Trachsel	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-14-5298	Mrs. Fred Hofmann	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema secondary 72 hours
ANTECEDENT CAUSES to acute Upper Respiratory Infection, 21 days
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Bronchitis, Carcinoma
DUE TO (c) of right lung, Lobectomy right 6 3/4 years
II. OTHER SIGNIFICANT CONDITIONS Emphysema
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-24, 1953, *to* 12-12, 1969, *that I last saw the deceased alive on* 12-12, 1969, *and that death occurred at* 11:05 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
T. M. Peterson, M.D.	Wallace, Idaho	12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-15-1969	St. Thomas Cemetery	Couer d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-22-69	Dale Harnell	Derrell Juelfs	E 518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5901
Local Reg. No. 90
Reg. Dist. No. 147

BIRTH NO.

RECEIVED DEC 29 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst
LENGTH OF STAY (In this place): 8Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): N. 300 Division 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Shoshone 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst
d. STREET ADDRESS (If rural, give location): N. 300 Division

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Zane		Smith	Dec. 12, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Feb. 28, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Miner 07	Mining	Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Zenithen Spickelmier	Indiana	Nettie Jacobs	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	520-05-5537	X Forest Spickelmier	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-12, 1969, *to* 12-12, 1969, *that I last saw the deceased alive on* 12-12, 1969 *and that death occurred at* about 5:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H14 G. M. Peterson, M.D.	Wallace, Idaho	12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/16/1969	Shoshone Men. Grdns	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-23-69	Joe Greene	Russell D. Mikel	E 520

FIRM NAME: Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5902
Local Reg. No. 184
Reg. Dist. No. 140

BIRTH NO.

RECEIVED DEC 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 118 - 7th. Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
d. STREET ADDRESS (If rural, give location): 118 - 7th. Street

3. NAME OF DECEASED (Type or Print): a. (First) Delmar; b. (Middle) Lee; c. (Last) Turley

4. DATE OF DEATH (Month) (Day) (Year): Dec. 12, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 13, 1919

9. AGE (In years last birthday): 50
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Maker 07

10b. KIND OF BUSINESS OR INDUSTRY: Bunker Hill

11. BIRTHPLACE (State or foreign country): Kellogg, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Steve Turley
BIRTHPLACE: Oklahoma

14. MOTHER'S MAIDEN NAME: Olive Gross
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War II 4

16. SOCIAL SECURITY NO.: 518-10-8602

17. INFORMANT'S OWN SIGNATURE: X Jean Turley
ADDRESS:

4123

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary heart disease
INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-7-68, 19___, *to* 12-12-69, 19___, *that I last saw the deceased alive on* 10-13-69, 19___, *and that death occurred at* 2:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD
23b. ADDRESS: Box 200 Wallace, Idaho
23c. DATE SIGNED: 12-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 12-17-69
24c. NAME OF CEMETERY OR CREMATORY: Smith Funeral Home
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 12-16-69
REGISTRAR'S SIGNATURE:

25. EMBALMER: Derrell J. Juelfs
LICENSE NO.: E - 518

FIRM NAME: Cornell's Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 24 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 7 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 15 1977

MAR 24 1978

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5903
Local Reg. No. 185
Reg. Dist. No. 140

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Shoshone 400 — DEC 24 1969
b. CITY OR TOWN: Silverton — LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Shoshone 400
c. CITY OR TOWN: Osburn
d. STREET ADDRESS (If rural, give location): 1105 Garden Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LeRoy	J.	Houghtaling	December 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	April 11, 1884	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Forest Service 08		Albany, New York	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Houghtaling	Unknown	Anna Morse	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-48-9693	Edna M. Houghtaling	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis of right colic artery — INTERVAL BETWEEN ONSET AND DEATH: 1wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Incarcerated strang. hernia — 1wk
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12-17-69	Incarcerated rt. inguinal hernia	YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP / (COUNTY) / (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-25-66, 19___, *to* 12-15-69, 19___, *that I last saw the deceased alive on* 12-15-69, 19___, *and that death occurred at* 10:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Box 200 Wallace, Idaho	12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-18-69	Greenwood Cemetery	Kellogg Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-19-69	[signature]	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 24 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5904
Local Reg. No. 28
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Shoshone 401 DEC 24 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg Bureau of Vital Statistics c. LENGTH OF STAY (In this place) 28 years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital 141	d. STREET ADDRESS (If rural, give location) 120 Railroad Avenue

3. NAME OF DECEASED (Type or Print) a. (First) THEODORE	b. (Middle) ANDREAS NELSON	c. (Last) NORGAARD	4. DATE OF DEATH (Month) (Day) (Year) Dec. 15, 1969	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 24, 1899	9. AGE (In years last birthday) 70 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner 07	10b. KIND OF BUSINESS OR INDUSTRY Mining	11. BIRTHPLACE (State or foreign country) Harrison, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hans K.N.Norgaard	BIRTHPLACE Denmark	14. MOTHER'S MAIDEN NAME Hattie Stuve	BIRTHPLACE Norway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO. 519-01-3228	17. INFORMANT'S OWN SIGNATURE X May Norgaard	ADDRESS Kellogg, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Arteriosclerotic Heart Disease	11 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus	8 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* Jan 30, 1958, *to* Dec 15, 1969, *that I last saw the deceased alive on* Dec 15, 1969, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Orland B Scott 461 (Degree or title)	23b. ADDRESS Kellogg Idaho	23c. DATE SIGNED 12/17/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec.20,1969	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) Kellogg, Idaho
DATE REC'D BY LOCAL REG. 12/19/69	REGISTRAR'S SIGNATURE [signature]	25. EMBALMER Russell D. Mikel	LICENSE NO. E-520

FIRM NAME Cornell's Maisel Funeral Ch.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 29 1969 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5905
Local Reg. No. 91
Reg. Dist. No. 14-1

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN: Kellogg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: West Shoshone Hospital 14-1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 401
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 2405 McKinley Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALVIN	FRED	KROLL	Dec. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Nov. 8, 1908	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager 01	Lead smelter	Canada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred A. Kroll	Germany	Freta C. Wurster	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War II	518-01-7750	X Mrs. Josephine Kroll	Kellogg, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral embolus	10 min
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Myocardial infarction	6 wks
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Recent acute upper GI hemorrhage	7 wks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 3, 1969, *to* Dec 18, 1969, *that I last saw the deceased alive on* Dec 18, 1969, *and that death occurred at* 10:a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orland B Scott 461 MD	Kellogg Idaho	Dec 19 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12/22/69	Forest Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-23-69	Joe Simms	Alan F. Peterson	E-534

FIRM NAME: Cornell's Maisel Fun'l Chap.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5906
Local Reg. No. 92
Reg. Dist. No. 1421

BIRTH NO.

RECEIVED JAN 22 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Smelterville
d. STREET ADDRESS (If rural, give location): 119 G Street

3. NAME OF DECEASED (Type or Print): a. (First) Curtis b. (Middle) Francis c. (Last) Ellig

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 12, 1912

9. AGE (In years last birthday): 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plant-Foreman 07

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): North Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles F. Ellig
BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Dorothy Morphew
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 474-01-1844

17. INFORMANT'S SIGNATURE: Flora D. Ellig
ADDRESS: 4189

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/21, 1969, *to* 12/21, 1969, *that I last saw the deceased alive on* 12/21, 1969, *and that death occurred at* 5:52 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Orland B Scott 461 (Degree or title) MD
23b. ADDRESS: Kellogg Idaho
23c. DATE SIGNED: 1/7/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/24/1969
24c. NAME OF CEMETERY OR CREMATORY: Restlawn
24d. LOCATION (City, town, or county) (State): Coeur D'Alene, Idaho

DATE REC'D BY LOCAL REG.: 1-12-70
REGISTRAR'S SIGNATURE: Joe Greene
25. EMBALMER: Russell D. Mitchell
LICENSE NO.: E 520
FIRM NAME: Cornell's Maisel Fun'l Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5907
Local Reg. No. 197
Reg. Dist. No. 140

BIRTH NO.

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Shoshone 400

b. CITY OR TOWN: Silverton

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Missouri 26

b. COUNTY: Douglas 555

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ava

d. STREET ADDRESS (If rural, give location): 731 S. Jefferson

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Minnie		McGill	Dec. 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	3-20-1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Squires, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elias Miller — BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Mary Farris — BIRTHPLACE: Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 494-20-1719

17. INFORMANT'S OWN SIGNATURE: Wm. McGill — ADDRESS: 731 S. Jeffers

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Penetrating Wound of Lower Right Abdomen Severing Large — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severe Internal Injuries & Shock

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	Highway 10 06	near Mullan, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Bus slid & hit guardrail

22. *I hereby certify that I attended the deceased from* 12-23, 1969, *to* 12-23, 1969, *that I last saw the deceased alive on* 12-23, 1969, *and that death occurred at* about 8:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
P. M. Peterson, M.D. 414 (Degree or title)	Wallace, Idaho	12-30-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-29-69	Springcreek	Ava, Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-31-69	Hall Cornell	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 21 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 9 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended January 15, 1970

Certificate of Death
STATE OF IDAHO

State File No. 5908
Local Reg. No. 188
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho 13 b. COUNTY: Shoshone 400

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY (In this place): DOA

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osburn

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East Shoshone Hospital 138

d. STREET ADDRESS (If rural, give location): 121 East Oak

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	Arthur	Jacob Wild	December 27, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 14, 1920	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hoistman 07	Mining	Spokane, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Wild	Unobt.	Ida Haye	Unob.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW11	519-10-5058	Ila M. Wild	Osburn

4369

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-21-54 *, 19____, to* 12-27-69 *, 19____, that I last saw the deceased alive on* 10-31-69 *, 19____, and that death occurred at* 5:00 a *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
E. E. Gnaedinger, M.D. 182 (Degree or title)	Box 200, Wallace, Idaho	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-30-1969	Restlawn Memorial Park	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-31-69	Dale L. Cornell	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED

JAN 14 1970

Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for George Arthur Jacob Wild (Name on Original Certificate) who died (Was Born or Died) on Dec 27, 1969 (Date of Event)
in Silverton, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#14-Mother's Maiden Name	Ida Haze	Ida Haye
#16 Social Security No.	not given	519-10-5058

Subscribed and sworn to before me this 12 day of January 1970

Notary Public, residing at Wallace

My commission expires 1-3-73

(Seal)

Signed Darrell J. Jacobs E-518
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Wallace Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho }
County of Shoshone } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 12 day of January 1970

Notary Public, residing at Wallace

My commission expires 1-3-73

(Seal)

Signed Danette Cordray
(Signature of Any Credible Person)

Wallace Idaho
(Street Address, City, State)

FORM DH 60-156

1-9-70 MF

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 188
Reg. Dist. No. 140

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
c. LENGTH OF STAY in this place: DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): East Shoshone Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osburn
d. STREET ADDRESS (If rural, give location): 121 East Oak

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	Arthur Jacob	Wild	12	27	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	April 14, 1920	49				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hoistman
10b. KIND OF BUSINESS OR INDUSTRY: Minning
11. BIRTHPLACE (State or foreign country): Spokane, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Wild — BIRTHPLACE: Unobt.
14. MOTHER'S MAIDEN NAME: Ida Haze — BIRTHPLACE: Unobt.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): Yes (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Ida M. Wild — ADDRESS: Osburn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-21-54, 19____, *to* 12-27-69, 19____, *that I last saw the deceased alive on* 10-31-69, 19____, *and that death occurred at* 5:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Box 200 Wallace, Idaho	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-30-1969	Restlawn Memorial Park	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: 12-31-69
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Derrell J. Juelfs — LICENSE NO.: E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 15 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5909
Local Reg. No. 11
Reg. Dist. No. 620

RECEIVED DEC 19 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 410 Teton
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 6 miles west of Driggs
LENGTH OF STAY (in this place) life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) his home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Area West
d. STREET ADDRESS (If rural, give location) none

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ernest	George	Bates	Dec 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	June 26, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Agriculture	Lymon, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas George Bates	England	Nora Alberta Foster	Maple Grove, Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-20-3014A	x Louise Bates	Driggs, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1957 Metastasis of Ca of Prostate — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1961, *to* Dec 4, 1969, *that I last saw the deceased alive on* Dec. 4 1969, *and that death occurred at* 8:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
219 K Heard MD	Driggs Idaho	12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial3	Dec 8, 1969	Wilford Cemetery	near St. Anthony, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-16-69	Ella Driggs	Robert O Bean	E456

FIRM NAME: Robert Bean Funeral Home,

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 12 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 4 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5910
Local Reg. No. 12
Reg. Dist. No. 620

Certificate of Death

RECEIVED JAN 23 1970 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Victor rural area
c. LENGTH OF STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): her home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Victor rural area
d. STREET ADDRESS (If rural, give location): rural

3. NAME OF DECEASED (Type or Print)
a. (First): Bessie
b. (Middle): Orgill
c. (Last): Gordon

4. DATE OF DEATH (Month) (Day) (Year): December 28, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 29, 1889
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 00
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Heber City, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Mark Orgill — BIRTHPLACE: Burslam, England
14. MOTHER'S MAIDEN NAME: Rachel Smith — BIRTHPLACE: Provo, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 518-54-0256
17. INFORMANT'S OWN SIGNATURE: S. D. Roy Gordon — ADDRESS: Victor, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Dehydration and

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cachexia
DUE TO (c): Advanced old age

INTERVAL BETWEEN ONSET AND DEATH: 2 wks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July *19*61*, to* 10-1*, 19*69*, that I last saw the deceased alive on* 11-1*, 19*69*, and that death occurred at* 7:00 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K Head MD 219
23b. ADDRESS: Driggs Id
23c. DATE SIGNED: 1-12-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 31, 1969
24c. NAME OF CEMETERY OR CREMATORY: Victor, Cemetery
24d. LOCATION (City, town, or county) (State): Victor, Idaho

DATE REC'D BY LOCAL REG.: 1-20-70
REGISTRAR'S SIGNATURE: Ella Griggs
25. EMBALMER: Robert G. Bean
LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robert Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5911
Local Reg. No. D 405
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420 DEC 8 1969
b. CITY OR TOWN: Kimberly
c. LENGTH OF STAY IN THIS PLACE: 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mtn. View Convalescent Cntr. 299

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN: Twin Falls
d. STREET ADDRESS (If rural, give location): 144 10th Avenue East

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLARENCE	RAY	BASOM	December 2, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	November 14, 1890	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Motel owner 22	Motel	LaCrosse, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theodore Basom	Michigan	Lydia McKinnis	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - - - - -	519-07-1126	Elson R. Basom	Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Lung abscess — 1 year.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-4- , 1969, *to* 12-2 , 1969, *that I last saw the deceased alive on* 11-20- , 1969, *and that death occurred at* 8:46p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George S. Brown M.D. 061	Twin Falls, Idaho	12-3-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12-5-69	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 5, 1969	Marna D. Marsh	William J. Boyd	E-490

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 12 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5912
Local Reg. No. D-407
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421 DEC 8 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY Bureau of Vital Statistics	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143	d. STREET ADDRESS (If rural, give location) 444 2nd Ave. No.

3. NAME OF DECEASED (Type or Print) a. (First) BERTIE	b. (Middle) PINK	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Dec. 3, 1969			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Jan. 7, 1891	9. AGE (In years last birthday) 78	IF UNDER 1 YR. Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Nova Scotia	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Max Pink	BIRTHPLACE Russia	14. MOTHER'S MAIDEN NAME Jennie Gluble	BIRTHPLACE Poland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) -----	16. SOCIAL SECURITY NO. 518-36-7737	17. INFORMANT'S OWN SIGNATURE Ralph Pink	ADDRESS Twin Falls		

4109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Myocardial Infarction	18 days.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary artery thrombosis	18 days.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 11-21, 19 69 *to* 12-3-, 19 69, *that I last saw the deceased alive on* 12-3-, 1969, *and that death occurred at* 9:10A *m., from the causes and on the date stated above.*

23a. SIGNATURE George E. Brown MD 061 (Degree or title)	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 12-4-69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 4, 1969	24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho
DATE REC'D BY LOCAL REG. Dec. 5, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER [signature]	LICENSE NO. E-340

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: White Mortuary
Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

APR 14 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5913
Local Reg. No. D-410
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 1 5 1969 Bureau of Vital Statistics

1. PLACE OF DEATH 421
a. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place) 5 years
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 273 Skyview Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 83328
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELSIE	LAVINA	McCLEARY	December 5, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Caucasian	Widowed	Jan 5, 1885	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Franklin Cooke	Wisconsin	Christiana McMillan	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-30-1293A	x Mary Virginia Geary	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4379

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral vascular accident	weeks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cereberal arteriosclerosis	months
DUE TO (c)	Generalized arteriesclerosis	years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic heart disease	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April 18, 1964, *to* December 5, 1969, *that I last saw the deceased alive on* November 30 1969, *and that death occurred at* 4:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	122 9th Ave. North Buhl	12-9-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 8, 1969	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 11, 1969	Marva D. Marsh	[signature]	E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5914
Local Reg. No. D-409
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 15 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 83316
c. LENGTH OF STAY in this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Union Pacific water tank 420

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) FILER 83328
d. STREET ADDRESS (If rural, give location) 205 5th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CARL	R.	BRUNKOW	Dec. 9, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 22, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engine watchman,	Railroad	Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Brunkow	Onaga, Kansas	Ida Helen Abitz	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	712-01-9593	Marva D. Brunkow	Forestdale Ave.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from January 3 1968 to December 9, 1969, that I last saw the deceased alive on December 8, 1969, and that death occurred at 4:45P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. W. Kendall MD	206 Martin St. Twin Falls	12-10-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1969	Filer IOOF Cemetery	Filer, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 11, 1969	Marva D. Marsh	Edgar J. Robertson	E-507

FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 16 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5915
Local Reg. No. D-411
Reg. Dist. No. 460

Certificate of Death

RECEIVED
DEC 19 1969
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 1 wk.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer (Rural)
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): CLARENCE
b. (Middle): CHESTER
c. (Last): COBB

4. DATE OF DEATH (Month) (Day) (Year): December 9, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 16, 1885
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: L. G. Cobb — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - - - - - -
16. SOCIAL SECURITY NO.: 518-18-6684
17. INFORMANT'S OWN SIGNATURE: Mildred Hostetler — ADDRESS: Filer, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

485X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia, bronchial — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 18, 1969, *to* Dec 9, 1969, *that I last saw the deceased alive on* Dec 9, 1969, *and that death occurred at* 6.20pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Max W Lawrence M.D. 085
23b. ADDRESS: 254 Martin St., Twin Falls, Idaho
23c. DATE SIGNED: 11 Dec 1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 12, 1969
24c. NAME OF CEMETERY OR CREMATORY: Filer I.O.O.F. Cemetery
24d. LOCATION (City, town, or county) (State): Filer, Idaho

DATE REC'D BY LOCAL REG.: Dec 15, 1969
REGISTRAR'S SIGNATURE: Marva D. Marsh
25. EMBALMER: William J. Boyd
LICENSE NO.: E-490

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5916
Local Reg. No. D-421
Reg. Dist. No. 460

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN: Buhl
c. LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION: Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 416 11th ave. north

3. NAME OF DECEASED (Type or Print): a. (First) Lizzie b. (Middle) Alberta c. (Last) Ewing

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 10, 1969

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Jan. 17, 1878

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Nebraska

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Albert Merchant
BIRTHPLACE: Penn.

14. MOTHER'S MAIDEN NAME: Nellie Spearing
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-24-5091

17. INFORMANT'S OWN SIGNATURE: X Gladys Hicks
ADDRESS: Buhl, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart Failure due to
ANTECEDENT CAUSES: Arteriosclerotic Heart Disease
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arthritis, severe
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:
(a) 2 weeks
(b) 7 years
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 21, 1963, *to* 12-10, 1969, *that I last saw the deceased alive on* 12-10, 1969, *and that death occurred at* 10:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Vern H Anderson M.D. (Degree or title)

23b. ADDRESS: Buhl, Idaho

23c. DATE SIGNED: 12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 15, 1969

24c. NAME OF CEMETERY OR CREMATORY: Buhl Cemetery

24d. LOCATION (City, town, or county) (State): Buhl Idaho

DATE REC'D BY LOCAL REG.: Dec. 19, 1969

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: Jim A Hopkins
LICENSE NO.: E-462

FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

BIRTH NO. DEC 19 1969

Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5917
Local Reg. No. D-415
Reg. Dist. No. 460

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place) 7 Months	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273	d. STREET ADDRESS (If rural, give location) 131 14th Avenue North

3. NAME OF DECEASED (Type or Print)	a. (First) CLARA	b. (Middle) BELLE	c. (Last) STALEY	4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1969
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Oct. 10, 1897	9. AGE (In years last birthday) 72 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Dayton, Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Edward Daniel	BIRTHPLACE Arkansas	14. MOTHER'S MAIDEN NAME Lilly May Barker	BIRTHPLACE Ohio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-34-2874	17. INFORMANT'S OWN SIGNATURE Margaret M. Hopwood	ADDRESS Rt. 3 Box 184-A Jerome, Ida.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Old Gen arteriosclerosis c Marble coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen debility
DUE TO (c) arthritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? Dec. 10

22. *I hereby certify that I attended the deceased from* July, 1967, *to* ~~Oct 10~~, 1967, *that I last saw the deceased alive on* ~~Oct~~ Dec. 9, 1969, *and that death occurred at* AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 07 A Drake M.D. 146	23b. ADDRESS 594 Hazeldd Drive	23c. DATE SIGNED 12 15 69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/13/69	24c. NAME OF CEMETERY OR CREMATORY Buhl	24d. LOCATION (City, town, or county) Buhl (State) Idaho
DATE REC'D BY LOCAL REG. Dec. 17, 1969	REGISTRAR'S SIGNATURE Vera Ryals	25. EMBALMER George Farmer	LICENSE NO. E-480

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5918
Local Reg. No. D-422
Reg. Dist. No. 460

RECEIVED DEC 23 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
LENGTH OF STAY (in this place): 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lincoln Courts

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 113 B. 1310 Main

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Josephine	C.	Kruckenberg	Dec. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	May 3, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Sylvan Grove, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Thaemert — BIRTHPLACE: Ill.
14. MOTHER'S MAIDEN NAME: O'Tillia Wunderlich — BIRTHPLACE: Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-18-7599D.
17. INFORMANT'S OWN SIGNATURE: Renata Graesche — ADDRESS: Buhl, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	minutes
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic heart disease	years
DUE TO (c)	Generalized Arteriosclerosis	years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes Mellitus	Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 2, 1966, *to* Dec. 11, 1969, *that I last saw the deceased alive on* Dec. 8, 1969, *and that death occurred at* 3:20 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	122 9th Ave. North Buhl,	12-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 16, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19, 1969	Marva D. Marsh	[signature]	E-482

FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5919
Local Reg. No. D-417
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 10 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 219 Harrison

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JULIA	H.	PERRY	Dec. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white	Widowed	July 3, 1891	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	Gudhjem, Denmark	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Carl Christian Hamner	unknown	Elizabeth Moller	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	518-28-4356	x Nursing Home Records	Ronald J. Hamilton

4339

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cerebral Thrombosis	7 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebro vascular arteriosclerosis	10 yr+
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	1. Arteriosclerotic heart disease 2. Pyelonephritis--chronic	2 yr+ 2 yr+

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-16 *, 19* 69 *, to* 12-11 *, 19* 69 *, that I last saw the deceased alive on* 12-10- *, 19* 69 *, and that death occurred at* 4:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
489 James H. Stoffel M.D.	Twin Falls, Idaho	12-12-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec. 13, 1969	Salt Lake City Cem.	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19, 1969	Marion D. Marsh	Ronald J. Hamilton	E-470

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5920
Local Reg. No. D-414
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 19 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 143
d. FULL NAME OF HOSPITAL OR INSTITUTION: DOA Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 311 Locust

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SUSAN		ROAN	Dec. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	never married	April 2, 1967	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02.	None	Pocatello, Idaho	USA

13. FATHER'S NAME / BIRTHPLACE	14. MOTHER'S MAIDEN NAME / BIRTHPLACE
Department of Public Assistance award	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	----	----	Burt Henderson Caseworker Public Welfare	Twin Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2722

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute Splenic rupture	1 hour
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Splenomegaly	2 years
DUE TO (c)	Niemann-Pick's disease (Histiocytosis "X")	2 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 6/23, 19 67, to 12/11, 19 69, that I last saw the deceased alive on 12/11, 19 69, and that death occurred at 7:40p m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F. M. Wright	MD	Twin Falls, Idaho	12/15/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 15, 1969	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 16, 1969	Marva D. Marsh	Lowell D. Hamilton	E-470

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
DEC 19 1969
Bureau of Vital Statistics

State File No. 5921
Local Reg. No. D-42
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Twin Falls 421 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls STAY (In this place):	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Twin Falls 421 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143	d. STREET ADDRESS (If rural, give location): Miller Apartments-Main Ave. No.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FLOYD	JESSIE	TIFFNEY	Dec. 11, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	white	Single	June 5, 1923	46		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Laborer	Rupert, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Glen Tiffney	Michigan	Betty Widner	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 4	518-22-7281	Glen Tiffney	Twin Falls, Id.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Acute pancreatitis 535X	16 hr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Gastritis	5 days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Subtotal gastric resection for bleeding ulcer	3 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10 Dec. 1969, *to* 11 Dec. 1969, *that I last saw the deceased alive on* 10 Dec. 1969, *and that death occurred at* 1:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James H. Gordon 489	M. D.	Twin Falls, Idaho	12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 13, 1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 16, 1969	Marva D. Marsh	Donald J. Hamilton	E-470

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 1 9 1969
JAN 2 2 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5922
Local Reg. No. D-423
Reg. Dist. No. 46C

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls #21
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls, Idaho
c. LENGTH OF STAY (In this place): 4 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazel Del Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls #21
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Maud; b. (Middle) Collins; c. (Last) Andrus

4. DATE OF DEATH: (Month) Dec. (Day) 12, (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 17, 1884

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lago, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fredrick W. — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Mellisea Fletcher — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-62-8217J1

17. INFORMANT'S SIGNATURE AND ADDRESS: Kathryn B Peck Soda Springs

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4409 Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c) Generalized arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* March 26, 1959, *to* December, 12-69 *that I last saw the deceased alive on* 12-12-69 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Willard H. Clark M.D.

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 12-18-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Dec. 12, 1969

24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery

24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: Dec. 19, 1969

REGISTRAR'S SIGNATURE: Marion D. Marsh

25. EMBALMER: Jerry D. Holman — LICENSE NO.: E-516

FIRM NAME: Whitman Matthews Mortuary Soda Springs, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5923
Local Reg. No. D-413
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421 DEC 19 1969	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY TwinFalls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 Bureau of Vital Statistics c. LENGTH OF (If in this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TwinFalls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) TwinFallsClinic Hosp. 144	d. STREET ADDRESS (If rural, give location) 573 Addison Ave West

3. NAME OF DECEASED (Type or Print) a. (First) WOODY	b. (Middle) T.	c. (Last) SEAL	4. DATE OF DEATH (Month) (Day) (Year) December 12,1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct.18,1878	9. AGE (In years last birthday) 91 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Trailer Sales Co.	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sneedsville , Tenn	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Richard Seal	BIRTHPLACE Tenn.		14. MOTHER'S MAIDEN NAME Martha Brewer	BIRTHPLACE UNK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-05-9079		17. INFORMANT'S OWN SIGNATURE Mrs. Darrell J. Dorton	ADDRESS TwinFal. Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerotic Cardiovascular Disease & Poor Circulation — 9 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-18, 1948, *to* 12-12, 1969, *that I last saw the deceased alive on* 12-12, 1969, *and that death occurred at* 7:50 A *m., from the causes and on the date stated above.*

23a. SIGNATURE D. G. McQuaby MD 338 (Degree or title)	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 12.12.69
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12.15.69	24c. NAME OF CEMETERY OR CREMATORY TwinFalls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho		
DATE REC'D BY LOCAL REG. Dec. 16, 1969	REGISTRAR'S SIGNATURE Vera Ryals	25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-470	FIRM NAME: White Mortuary Twin Falls, Idaho	

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 19 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5924
Local Reg. No. D-419
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY IN this place
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 143 Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 413 N. Broadway Avenue

3. NAME OF DECEASED (Type or Print) a. (First) ORA b. (Middle) G. c. (Last) DAISS

4. DATE OF DEATH (Month) Dec. (Day) 14, (Year) 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Oct. 2, 1888

9. AGE (In years last birthday) 81
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Eustis, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Methven
BIRTHPLACE No Record

14. MOTHER'S MAIDEN NAME Mary E. Yaryan
BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-28-7362

17. INFORMANT'S OWN SIGNATURE L. A. Daiss RFD #1 ADDRESS Buhl, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH * (a) Heart Failure due to — INTERVAL BETWEEN ONSET AND DEATH 12-14-69

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (2) Cerebral Hemorrhage — 11-4-69.
DUE TO (c) (3) with left Hemaplegia & Paralysis of throat

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gastrostromy to feed — 11-13-69
Patient

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-7, 1969, *to* 12-14, 1969, *that I last saw the deceased alive on* 12-13, 1969, *and that death occurred at* 9:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Vern H Anderson, MD (Degree or title)

23b. ADDRESS Buhl, Ida

23c. DATE SIGNED 12-16-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/19/69

24c. NAME OF CEMETERY OR CREMATORY Buhl

24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 19, 1969

REGISTRAR'S SIGNATURE Marna D. Marsh

25. EMBALMER George Farmer

LICENSE NO. E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 5925
Local Reg. No. D-431
Reg. Dist. No. 460

BIRTH NO. DEC 30 1969

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (In this place): 13 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: 701 12th Avenue North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 701 12th Avenue North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MATT		PRETL	Dec. 14, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Sept. 21, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Agriculture	Mrakov, Czechoslovokia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jan Pretl	Czechoslovokia	No Record	Czechoslovokia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-42-5503	Mrs. Matt Pretl	701 12th N. Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Coronary occlusion	minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	years ######
DUE TO (c)	Generalized arteriosclerosis	Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cancer of prostate	Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 19 61 *to* December 14, 19 69, *that I last saw the deceased alive on* December 14, 19 69, *and that death occurred at* 9.30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	122 9th Ave. No. Buhl	12-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	12/18/69	Buhl	Buhl	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 29, 1969	Mama D. Marsh	George Farmer	E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH--63021

DEC 3 0 1969
JAN 9 1970
APR 6 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5926
Local Reg. No. D-428
Reg. Dist. No. 460

RECEIVED DEC 29 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 129 5th Ave. E.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Delena	Pearl	Alban	Dec. 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Dec. 12, 1897	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Vernon, British Columbia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Chester H. Archibald	Canada	Ella J. Campbell	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-------	518-09-6665-A	Mrs. H. L. Hiles	Twin Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Carcinoma of the lung — INTERVAL BETWEEN ONSET AND DEATH: 11 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinomatosis with boney metastasis — 11 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1 Sept. 1969, to 15 Dec. 1969, that I last saw the deceased alive on 15 Dec. 1969, and that death occurred at 8:50 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James H. Jeffers MD	Twin Falls, Idaho	12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial 3	12-16-1969	Elmwood Cemetery	Gooding,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 24, 1969	Marna D. Marsh	Eddie Leach	E-511

FIRM NAME Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 26 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5927
Local Reg. No. D-416
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
DEC 23 1969
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place) 2 mo.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sky View Manor Nursing Home 273	d. STREET ADDRESS (If rural, give location) 640 Filer Av. West

3. NAME OF DECEASED (Type or Print)	a. (First) ALMA	b. (Middle)	c. (Last) HADLEY	4. DATE OF DEATH (Month) (Day) (Year) December 15, 1969
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 15, 1880	9. AGE (In years last birthday) 89 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Utah	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard Hadley	BIRTHPLACE England		14. MOTHER'S MAIDEN NAME Lucy Alestia Quigley	BIRTHPLACE England
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-42-9413A		17. INFORMANT'S OWN SIGNATURE (By Mail) Ronald J. Hamilton	ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

2509

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Terminal heart failure [illegible] probable coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Sen arteriosclerosis yes

DUE TO (c) Diabetes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

old age

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 14, 1969 *to* Dec 15, 1969, *that I last saw the deceased alive on* Dec 8, 1969 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE B. A. Drake M.D. (Degree or title)	23b. ADDRESS 594 Hazeldell	23c. DATE SIGNED 12 1 69
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3	24b. DATE Dec. 15, 1969	24c. NAME OF CEMETERY OR CREMATORY Swan Lake Cemetery
24d. LOCATION (City, town, or county) Bannock County	(State) Idaho	
DATE REC'D BY LOCAL REG. Dec. 19, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Ronald J. Hamilton
LICENSE NO. 470		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

MAR 1 6 1987

JUN 1 6 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5928
Local Reg. No. D-426
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 29 1969

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bureau of Rural
c. LENGTH OF STAY in this place

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY T. Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 114 B Lincoln Court

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

3. NAME OF DECEASED (Type or Print) a. (First) ERNEST b. (Middle) c. (Last) PRITCHARD
4. DATE OF DEATH (Month) (Day) (Year) December 15, 1969
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 30, 1888
9. AGE (In years last birthday) 81
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Seward, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas E. Pritchard BIRTHPLACE Wiltshire, England
14. MOTHER'S MAIDEN NAME Emiline Partain BIRTHPLACE Georgia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-32-0211
17. INFORMANT'S OWN SIGNATURE Pearl Pritchard ADDRESS Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) 4109 Cardiopulmonary Arrest — INTERVAL BETWEEN ONSET AND DEATH Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Massive Myocardial Infarction 48-72 hr
DUE TO (c) and Pulmonary Edema ASHD

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 19 69 *to* 12/15/69, 19 69, *that I last saw the deceased alive on* 12/15/69, 19 ___, *and that death occurred at* 2:26 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 919 (Degree or title) M.D.
23b. ADDRESS Buhl, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12 - 18 - 69
24c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Dec. 24, 1969
REGISTRAR'S SIGNATURE Marva O. Marsh
25. EMBALMER James C. Reynolds
LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

SEP 3 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5929
Local Reg. No. D-425
Reg. Dist. No. 460

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

DEC 23 1969

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Twin Falls 421

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Blaine 070

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)

a. (First): Lee

b. (Middle): Eugene

c. (Last): Reynolds

4. DATE OF DEATH (Month) (Day) (Year): Dec. 15 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 8, 1909

9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cattle Buyer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Adams Reynolds — BIRTHPLACE: Ind.

14. MOTHER'S MAIDEN NAME: Elizabeth Estelle Littlefield — BIRTHPLACE: Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 572-03-3906

17. INFORMANT'S OWN SIGNATURE: Mrs. Lee Reynolds — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes mellitus

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-13, 19 69, *to* 12-15, 19 69, *that I last saw the deceased alive on* 12-15-, 19 69, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. W. Kendall M.D. 277

23b. ADDRESS: 206 Martin St. T.F.

23c. DATE SIGNED: 12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 12-19-69

24c. NAME OF CEMETERY OR CREMATORY: LaMar Cemetery

24d. LOCATION (City, town, or county) (State): LaMar Colorado

DATE REC'D BY LOCAL REG.: 12-19-69

REGISTRAR'S SIGNATURE: Marva D. Marsh

25. EMBALMER: Ronald J. Hamilton

LICENSE NO.: E-470

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 18 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 15 1970

JAN 30 1976

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

OCT 20 2009

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5930
Local Reg. No. D-420
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 23 1969 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
d. STREET ADDRESS (If rural, give location): P.O. Box 12

3. NAME OF DECEASED (Type or Print): a. (First) RILLA b. (Middle) A. c. (Last) PRESTON

4. DATE OF DEATH (Month) (Day) (Year): December 16, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: October 4, 1908

9. AGE (In years last birthday): 61
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beauty Operator 21

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Muscatine Co., Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rolla Fry
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Opal Wells
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: Not available

17. INFORMANT'S OWN SIGNATURE: James L Preston
ADDRESS: Arco, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Acute Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic
DUE TO (c) heart disease — 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3-28, 1967 *to* 12/16/, 1969, *that I last saw the deceased alive on* 12-15, 1969, *and that death occurred at* 12:27 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dean 003 H Ahlea M.D.

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/18/69

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 19, 1969

REGISTRAR'S SIGNATURE: Mama D. Mason

25. EMBALMER: Paul D. Reynolds

LICENSE NO.: E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5931
Local Reg. No. D-439
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JAN 6 1970 Vital Statistics Bureau of Health

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
LENGTH OF STAY (in this place): 32 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 725 12th Ave. North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 725 12th Ave. North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Olive	Marie	Morrison	Dec. 18, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	Sept. 24, 1911	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Corral, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Babington — BIRTHPLACE: Oregon
14. MOTHER'S MAIDEN NAME: Olive Hedden — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-48-7877
17. INFORMANT'S OWN SIGNATURE: Irene Morrison — ADDRESS: Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1748 Carcinoma of breast with metastases to lungs
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) many bones
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jan 7, 1965	Left breast removed	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 4, 1965, *to* Dec 18, 1969, *that I last saw the deceased alive on* Nov 25, 1969, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H. Anderson MD	Buhl, Idaho	Dec 19, 1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 20, 1969	Buhl Cemetery	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 5 1970	Marva D. Marsh	Jim A Hopkins	E-482

FIRM NAME: Hopkins-Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 6 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 14 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 24 1988

MAY 16 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5932
Local Reg. No. D-427
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 29 1969 Bureau of Vital

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH

a. COUNTY: Twin Falls 42

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)

a. STATE: Idaho

b. COUNTY: Twin Falls 42

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls, Id

d. STREET ADDRESS (If rural, give location): 247 9th Ave. Nth.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARSHALL	C	JOHNSON	12 - 19 - 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	3 - 13 - 1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auditor 19	Farm Credit	Lebanon, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles D. Johnson	Unknown	Lottie E. Barrows	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes W.W.# 2	491-12-1369	Lottie E. Decker	Twin Falls, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5349

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Jejunal ulcer with peritonitis — Interval between onset and death: Unknown

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) 2. Myacardial infarction from A S H D — 2-3- weeks

DUE TO (c) Pulmonary emphysemia with cor pulmonale — unknown

DUE TO (c) Encephalomyelacia from recent cerbral vasculer accident — 1 month

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes XX No

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12/3, 1969, *to* 12/19, 1969, *that I last saw the deceased alive on* 12/19, 1969, *and that death occurred at* 7:01 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Twin Falls, Idaho	12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-22-1969	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 24, 1969	Marna D. Marsh	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 6 1970
JAN 14 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 19 1970
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5933
Local Reg. No. D-424
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42 — DEC 23 1969
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: California 05 — b. COUNTY: Orange 555
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Port Beach 92660
d. STREET ADDRESS (If rural, give location): 3400 Via Oporto

3. NAME OF DECEASED (Type or Print): a. (First) IRENE — b. (Middle) D. — c. (Last) LEE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 19, 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Nov. 18, 1902

9. AGE (In years last birthday): 67
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Dwyer — BIRTHPLACE: Chicago, Illinois

14. MOTHER'S MAIDEN NAME: Mary Rose Burke — BIRTHPLACE: Chicago, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 525-09-1989

17. INFORMANT'S OWN SIGNATURE: by telegram — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 5 yr+
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Diabetes mellitus — 20 yr

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 17 Dec., 19 69, *to* 19 Dec., 19 69, *that I last saw the deceased alive on* 19 Dec., 19 69, *and that death occurred at* 12/40a m., *from the causes and on the date stated above.*

23a. SIGNATURE: James H. Jeffers — (Degree or title): M. D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: Dec. 20, 1969
24c. NAME OF CEMETERY OR CREMATORY: Mt. View Crematory
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Dec. 19, 1969
REGISTRAR'S SIGNATURE: Marma O. Marsh
25. EMBALMER: Jerry D. Johnson
LICENSE NO.: E-516

FIRM NAME: White Mortuary
Twin Falls, Idaho

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 24 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 2 1970 Bureau of Vital Statistics

State File No. 5934
Local Reg. No. D-434
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421 a. STATE Idaho 13 b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF RESIDENCE (In this place)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls, 83301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 478 Blue Lakes Blvd. North 000	d. STREET ADDRESS (If rural, give location) 478 Blue Lakes Blvd. North

3. NAME OF DECEASED (Type or Print)	a. (First) R.	b. (Middle) GEORGE	c. (Last) BENNETT	4. DATE OF DEATH (Month) (Day) (Year) December 22, 1969
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 23, 1904	9. AGE (In years last birthday) 65 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman 22	10b. KIND OF BUSINESS OR INDUSTRY Business	11. BIRTHPLACE (State or foreign country) Wisconsin	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Bennett	BIRTHPLACE UNK	14. MOTHER'S MAIDEN NAME Mary Murphy	BIRTHPLACE UNK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ----	16. SOCIAL SECURITY NO. 541-07-0515A	17. INFORMANT'S OWN SIGNATURE x Myrtle Bennett	ADDRESS 478 B.L. No. Twin Falls	

4123

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac Arrest from	Immediate
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	A.S.H.D. c̄ Previous	20 yrs
DUE TO (c)	Myocardial Infarction	20 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-22, 1959, *to* Dec. 22, 1969, *that I last saw the deceased alive on* 12/4, 1969 *and that death occurred at* 7:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 578 (Degree or title)	23b. ADDRESS 204 4th Ave. E. Twin Falls, Idaho	23c. DATE SIGNED 12/23/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 26, 1969	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho
DATE REC'D BY LOCAL REG. Dec 30, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Edgar J. Robertson	LICENSE NO. E-507

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

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DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5935
Local Reg. No. D-429
Reg. Dist. No. 460

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY T.Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 237 Van Buren

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES
b. (Middle) S.
c. (Last) CONOVER

4. DATE OF DEATH (Month) (Day) (Year) December 22, 1969

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 26, 1890
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maroa, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Conover — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Mary Sanderson — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-16-3461A
17. INFORMANT'S OWN SIGNATURE W. H. Brown — ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypoxemia due to aspiration of food in Tracheo bronchial tree — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Stroke due to arterio sclerosis, generalized — 3 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* 12/22/__, 1969, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 1:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Werner H. Kramer 293 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 12-24-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/24/69
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Dec. 26, 1969
REGISTRAR'S SIGNATURE Marva D. Marsh
25. EMBALMER James C. Reynolds — LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 17 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 5936
Local Reg. No. D. 433
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420 JAN 2 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Polèline Road East Rt. #3 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) Rural--Polèline Road East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HELEN	M.	HINSHAW	December 23, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Caucasian	Married	June 3, 1907	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Collins	Missouri	Hattie Mae Clinton	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO ---------	519-46-4413	Jose Martin	Twin Falls

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

4109

Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardial Vascular disease
DUE TO (c) Congestive Heart failure

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetic

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Coroners Investigation Only to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:30P m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lloyd O. Edwards 583	Coroner	R#3 Twin Falls Ida.	Dec 27-1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 27, 1969	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 30, 1969	Marie D. Morse	Edgar J. Robertson	E-507

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

Certificate of Death
STATE OF IDAHO

State File No. 5937
Local Reg. No. D-435
Reg. Dist. No. 460

BIRTH NO. JAN 2 1970

Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (In this place) 1 week	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143	d. STREET ADDRESS (If rural, give location) R.F.D. # 2

3. NAME OF DECEASED (Type or Print)	a. (First) JOSEPH	b. (Middle) PETER	c. (Last) PRILUCIK	4. DATE OF DEATH (Month) (Day) (Year)	Dec. 23, 1969
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 17, 1898	9. AGE (In years last birthday) 71	IF UNDER 1 YR. Months Days / IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (State or foreign country) Ellinger, Texas	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Prilucik	BIRTHPLACE Moravia	14. MOTHER'S MAIDEN NAME Mary Vyoral	BIRTHPLACE Moravia		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-42-2198	17. INFORMANT'S OWN SIGNATURE RFD # 2 Helen Prilucik	ADDRESS Buhl, Idaho		

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

185X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Uremia	1 week
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Adenocarcinoma of Prostate gland	unknown
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Acute Urinary Retention	

19a. DATE OF OPERATION 12/16/69	19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Prostate gland with invasion of Trigone	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/8/68, 19__, *to* 12/23, 1969, *that I last saw the deceased alive on* 12/23, 1969, *and that death occurred at* 7:10 pm., *from the causes and on the date stated above.*

23a. SIGNATURE George T Davis 132 (Degree or title) MD	23b. ADDRESS Twin Falls, Idaho	23c. DATE SIGNED 12/29/69	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/27/69	24c. NAME OF CEMETERY OR CREMATORY Buhl	24d. LOCATION (City, town, or county) Buhl, (State) Idaho
DATE REC'D BY LOCAL REG. Dec. 31, 1969	REGISTRAR'S SIGNATURE Marva D. Marsh	25. EMBALMER Robert F. Dickard	LICENSE NO. E-312

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 1970

AUG 4 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED
JAN 6 1970
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5938
Local Reg. No. D-441
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Twin Falls 420	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl — c. LENGTH OF STAY (In this place): 4 Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205	d. STREET ADDRESS (If rural, give location): 205 8th Ave. South

3. NAME OF DECEASED (Type or Print)	a. (First): MARY	b. (Middle): FILKINS	c. (Last): SWIGER	4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1969
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: May 2, 1887	9. AGE (In years last birthday): 82 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Minneapolis, Minnesota	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Fred Filkins — BIRTHPLACE: No Record		14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE:		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):	16. SOCIAL SECURITY NO.: 518-30-0805D	17. INFORMANT'S OWN SIGNATURE: William L. Watt RED # 4	ADDRESS: Buhl, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/23

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease — sev. year

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Obesity, mod sev. Partial obstruction of stomach due to Pyloric obstruction — 1 yr

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 6-1, 1956, *to* Dec 23, 1969, *that I last saw the deceased alive on* Dec 22, 1969, *and that death occurred at* 7:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Vern H Anderson, MD 011 (Degree or title)	23b. ADDRESS: Buhl, Idaho	23c. DATE SIGNED: 12/31/69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12/27/69	24c. NAME OF CEMETERY OR CREMATORY: Buhl	24d. LOCATION (City, town, or county) (State): Buhl, Idaho
DATE REC'D BY LOCAL REG.: Jan. 5, 1970	REGISTRAR'S SIGNATURE: Marva D. Marsh	25. EMBALMER: Robert F. Dickard	LICENSE NO.: E-312

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5939
Local Reg. No. D-440
Reg. Dist. No. 460

BIRTH NO. RECEIVED JAN 6 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 420
a. STATE Idaho
b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 820 North Broadway Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ETHEL	J.	HADLEY	Dec. 24, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Feb. 17, 1894	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Okeene, Oklahoma	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Johnson	No Record	Annie Norton	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	454-01-7206	Mrs Clara Stovall	Buhl Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4589

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Hemorrhage into abdominal wall from left inferior epigastric artery & generalized purpura & bleeding from duodenal mucosa.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Long standing self medication with cortisone of undetermined dosage brought in from Mexico for treatment of Rheumatoid Arthritis.

DUE TO (c) Subcapital fracture of right femur-old-

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. not previously recognized or treated.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes [X] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* December 23, 19 69 *to* December 24, 19 69, *that I last saw the deceased alive on* December 23, 19 69, *and that death occurred at* 6:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marilyn 422 M Ford	1216 Filer Ave. E. Twin Falls, Idaho	12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/27/69	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 5, 1970	Marva D. Marsh	Robert F. Dickard	E-312

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 2 8 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED
JAN 2 1970
Bureau of Vital Statistics

State File No. 5940
Local Reg. No. D-432
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH a. COUNTY Twin Falls 421 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301 c. LENGTH OF STAY (In this place) d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hosp. 144	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Twin Falls 421 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls, 83301 d. STREET ADDRESS (If rural, give location) 1231 10th Ave. East

3. NAME OF DECEASED (Type or Print) a. (First) HARRY	b. (Middle)	c. (Last) POVEY	4. DATE OF DEATH (Month) (Day) (Year) December 24, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 28, 1893	9. AGE (In years last birthday) 76 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney 16	10b. KIND OF BUSINESS OR INDUSTRY Law	11. BIRTHPLACE (State or foreign country) Waterloo, England	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown	BIRTHPLACE	14. MOTHER'S MAIDEN NAME unknown	BIRTHPLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI 3	16. SOCIAL SECURITY NO. 519-46-4596	17. INFORMANT'S OWN SIGNATURE Pre arrangement records	ADDRESS	

188X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Carcinomatosis	1 month
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Carcinoma of bladder	3 months
DUE TO (c)	c̄ Metastasis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-28, 1960, *to* 12-24, 1969, *that I last saw the deceased alive on* 12-24, 1969, *and that death occurred at* 12 10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE D. A. McQuisky MD 338 (Degree or title)	23b. ADDRESS Twin Falls Idaho	23c. DATE SIGNED 12-28-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Removal 3	24b. DATE Dec. 30, 1969	24c. NAME OF CEMETERY OR CREMATORY Mt. View Crematory	24d. LOCATION (City, town, or county) (State) Boise, Ada, Idaho
DATE REC'D BY LOCAL REG. Dec 30, 1969	REGISTRAR'S SIGNATURE Maria D. Marsh	26. EMBALMER Jerry D. Holman	LICENSE NO. E-516

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: White Mortuary, Twin Falls, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 5 1970
JAN 21 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED JAN 2 1970 Bureau of Vital Statistics

State File No. 5941
Local Reg. No. D-436
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) 421
a. STATE Idaho b. COUNTY Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 435 3rd Ave. East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ruby	Myrtle	Anderson	12 - 25 - 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Never Married	9 - 19 - 1887	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Book-Keeper 19		Hermosa, South Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Levi Anderson		Jessie Pedrick	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-7630	Charles G. Allen	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

1990

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pleural effusion from

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b) Malignancy Primary
DUE TO (c) Site Undetermined

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 4 , 19 57 mo 12/25 , 19 69 , that I last saw the deceased alive on 8/28 , 19 69 , and that death occurred at 8:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 578	M.D.	Twin Falls, Idaho	12/29/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-29-1969	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 31, 1969	Marna O. Marsh	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 2 1970

JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 7 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 12 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

OCT 21 1971

JUL 17 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

NOV 3 1972

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

FEB 20 1997

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5942
Local Reg. No. D-443
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JAN 2 1970 Bureau of Vital Statistics

421 423

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 443

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly 83341
d. STREET ADDRESS (If rural, give location): 340 Monroe St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LILLIE	M.	CLIMER	December 26, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Married	Sept. 3, 1892	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Rayborn, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Helsley	unknown	Jane Austin	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (Same)	ADDRESS
No	518-09-5990	[signature]	[illegible]

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5-6 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 21 Dec, 19 69, *to* 25 Dec, 19 69, *that I last saw the deceased alive on* 25 Dec 19 69, *and that death occurred at* 6:05a *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Werner H Kramer 293 (Degree or title)	Twin Falls, Idaho	12-29-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 29, 1969	Sunset Memorial Park	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 5, 1970	Marva O. Marsh	Jerry D. Holman	E-516

FIRM NAME: White Mortuary, Twin Falls, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 9 1975
APR 30 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

BIRTH NO. JAN 1 3 1970

Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5943
Local Reg. No. D-445
Reg. Dist. No. 460

1. PLACE OF DEATH a. COUNTY: Twin Falls 421	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls m — c. LENGTH OF STAY (In this place): 5 Years	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Skyview Manor 273	d. STREET ADDRESS (If rural, give location): Skyview Manor Rest Home

3. NAME OF DECEASED (Type or Print) a. (First): CHARLES	b. (Middle):	c. (Last): STEWART	4. DATE OF DEATH (Month) (Day) (Year): December 26, 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Nov. 9, 1879	9. AGE (In years last birthday): 90 — IF UNDER 1 YR. Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheepman 04	10b. KIND OF BUSINESS OR INDUSTRY: Livestock	11. BIRTHPLACE (State or foreign country): Inverness, Scotland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Charles Stewart	BIRTHPLACE: Scotland	14. MOTHER'S MAIDEN NAME: Sarah Ann Stewart	BIRTHPLACE: Scotland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518-40-9939	17. INFORMANT'S OWN SIGNATURE: Jean Margaret Thompson	ADDRESS: Filer	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/21

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Terminal heart failure — INTERVAL BETWEEN ONSET AND DEATH: short time

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive arterial cortex — years

DUE TO (c) Hypertensive arterial cortex — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1966, *to* Dec 26, 1969, *that I last saw the deceased alive on* Dec 23, 1969, *and that death occurred at* a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. G. Drake 146 (Degree or title) MD	23b. ADDRESS: 594 H Eagle Lake Drive	23c. DATE SIGNED: 12-31-69	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12/29/69	24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho
DATE REC'D BY LOCAL REG.: Jan. 12, 1970	REGISTRAR'S SIGNATURE: Marva D. Marsh	25. EMBALMER: Robert F. Dickard	LICENSE NO.: E-312

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital

State File No. 5944
Local Reg. No. D 442
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls (42) JAN 6 1970
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (143) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) (421)
a. STATE: Idaho
b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 203 4th Street North

3. NAME OF DECEASED (Type or Print)
a. (First): WALTER
b. (Middle): RALIEGH
c. (Last): WESCOTT

4. DATE OF DEATH (Month) (Day) (Year): December 26, 1969

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 26, 1883

9. AGE (In years last birthday): 86
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (04)

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: UNK Willet
BIRTHPLACE: UNK

14. MOTHER'S MAIDEN NAME: UNK
BIRTHPLACE: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-34-4274

17. INFORMANT'S OWN SIGNATURE: E R Wescott
ADDRESS: Twin Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

(4109)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12/25, 19 69 to 12/26, 19 69 (Patient of Dr. Affleck) *that I last saw the deceased alive on* 12/26, 19 69 *and that death occurred at* 9:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): (578) C. Gwinn Wall

23b. ADDRESS: 204 4th Ave. E. Twin Falls, Idaho

23c. DATE SIGNED: 12/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 30, 1969

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 5, 1970

REGISTRAR'S SIGNATURE: Marna O. Marsh

25. EMBALMER: Jerry L. Holman

LICENSE NO.: E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service FORM DH–63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5945
Local Reg. No. D-437
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 121 4th Avenue South 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY T.Falls 42c
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Kimberly
d. STREET ADDRESS (If rural, give location) R.R.#1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	F.	THEISEN	December 28,1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	April 21,1919	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Automobile Salesman 24		Valentine, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William T.Theisen	South Dak.	Eleanor Binganheimer	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.#2 4	507-03-9377	Mrs William F Theisen	Kimberly, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

955X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Massive skull trauma- self inflicted — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
2 Suicide	Motel 31	Twin Falls 1342	Twin Falls	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Dec.28,1969 11:00a.m.		Gunshot in head.

22. *I hereby certify that I attended the deceased from* Did not attend-Coroners investigation only *last saw the deceased alive on* _____, 19____, *and that death occurred at* 11:00a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clayton C. Edwards M.D.	Coroner	Twin Falls, Idaho	12/31/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1/2/70	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	26. EMBALMER	LICENSE NO.
Jan. 2, 1970	Marva D. Marsh	Paul D. Reynolds	E-495

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 6 1970
JAN 9 1970
JAN 16 1970
JAN 21 1970
JAN 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5946
Local Reg. No. D-438
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JAN 5 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY T.Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls Rural
d. STREET ADDRESS (If rural, give location) R.R.#3

3. NAME OF DECEASED (Type or Print) a. (First) DELCIE b. (Middle) F. c. (Last) DENNEY

4. DATE OF DEATH (Month) (Day) (Year) December 30, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH April 4, 1888

9. AGE (In years last birthday) 81
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Grandview, Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Isaac Biggerstaff
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME Maria Hull
BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-20-8414

17. INFORMANT'S OWN SIGNATURE Edythe D. Kooney ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH * (a) Arteriosclerotic dis. with hypertension and cerebral hemorrhage
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 2. Pneumonia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
1 month
36 hours

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2-1956, 19___, *to* 12/30/, 19 69, *that I last saw the deceased alive on* 12-30-69, 19___, *and that death occurred at* 8:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE Harwood H Stowe, 508 (Degree or title) M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 1-2-70

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 1/3/70

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Jan. 2, 1970

REGISTRAR'S SIGNATURE Marva D. Marsh

25. EMBALMER James C. Reynolds

LICENSE NO. E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JAN 6 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5947
Local Reg. No. D-444
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in hospital): 143
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 42
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 220 Van Buren

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ISABELLE	SOPHIA	HUMPHREY	Dec. 31, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	Nov. 12, 1889	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alex Stoddard	Utah	no record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
no	544-36-0030	x Clara May Foster Jerome, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4409

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Bronchopneumonia	1 day
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Generalized arteriosclerosis	5 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	uremia	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - -	- - -	- - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
- - - - m.		- - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 9-2-58, 19__, *to* 12-31-69, 19__, *that I last saw the deceased alive on* 12-31-69, 19__ *and that death occurred at* 2:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. N. Clark M.D.	Twin Falls, Idaho	1-5-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	1-3-70	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 8, 1970	Maria D. Marsh	Dale L. Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 25 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5948
Local Reg. No. 24
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Valley 43c
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Valley 43c
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location) Box 193

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RUSSELL	VERNON	FAUST	November 15, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Jan 31, 1902	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 06	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer - maintenance work		Lincoln, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Faust	Nebraska	Cora Brainard	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-14-2917-A	Corine Faust	McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4419

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) RUPTURED AORTIC ANEURYSM

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) AORTIC ARTERIOSCLEROSIS
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 14, 19 69 *to* Nov. 15, 19 69, *that I last saw the deceased alive on* Nov. 15, 19 69, *and that death occurred at* 4:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold Stokes M.D. 391	McCall, Idaho	12-13-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	11/18/69	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 15-1969	Myrtle A. Gardner	Burton E. Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

FEB 1 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5949
Local Reg. No. 23
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
DEC 18 1969
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Elk Summit
LENGTH OF STAY (In this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Near Elk Summit

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Idaho 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Rt. # 1, Middleton Road

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) LONELL c. (Last) "LONNY" JOHNSON

4. DATE OF DEATH (Month) (Day) (Year): Dec. 4, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	July 1, 1932	37		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Exec. Director CS	Economic Govt- Opportunity	Alamosa, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theodore R. Johnson	Colorado	Sadie J. Jack	Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes 1953- 1955 6	524-32-3597	X Mrs. Lonny Johnson	Nampa

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Broken neck- crushed chest	instant
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Forest Road 06	rural McCall 13430	Valley	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Dec 4, 1969 6 P m.		vehicle rolled on victim

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton E. Walker 583 4	Coroner	McCall Idaho	12/7/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	12/9/69	Hillcrest Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 9- 1969	Myrtle M Gardner	Richard W. Mossbrook	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service FORM DH–63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 18 1969
DEC 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5950
Local Reg. No. 25
Reg. Dist. No. 3/8

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
LENGTH OF STAY (In this place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby
d. STREET ADDRESS (If rural, give location) no record

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) c. (Last) HAYES
4. DATE OF DEATH (Month) (Day) (Year) December 8, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	March 26, 1881	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
common laborer 06		Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Hayes	England	Emma Turner	Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-60-4488-T	Nursing Home records	

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	Cardiac standstill	5 min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Myocardial infarction	3 Days
DUE TO (c)	Arterio sclerotic Heart Disease	15 years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-23-1967 *to* 12-8-1969, *that I last saw the deceased alive on* 12-8-69, 19____, *and that death occurred at* 12:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wayne F. Allen 006 MD	McCall Idaho	12-19-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 3	Dec 13, 1969	Mountain View Cemetery	Picatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 24-1969	Myrtle M Gardner	Burton E Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5951
Local Reg. No. 26
Reg. Dist. No. 310

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 43c Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (In this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meadows
d. STREET ADDRESS (If rural, give location) Box 21

3. NAME OF DECEASED (Type or Print) a. (First) JESSIE b. (Middle) MAY c. (Last) EVANS

4. DATE OF DEATH (Month) (Day) (Year) December 16, 1969

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH Oct 5, 1880

9. AGE (In years last birthday) 89
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Harvard, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David Ormsbee BIRTHPLACE New York

14. MOTHER'S MAIDEN NAME Betsy BIRTHPLACE New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-54-3425-T

17. INFORMANT'S OWN SIGNATURE Hospital and Family records ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4123

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) BRONCHIAL PNEUMONIA.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. FRACTURE OF PELVIS

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 14, 1969, *to* Dec 16, 1969, *that I last saw the deceased alive on* Dec 16, 1969, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title) 391 Ronald S. Roberts M.D.

23b. ADDRESS McCall, Idaho

23c. DATE SIGNED 12-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE Dec 19, 1969

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill

24d. LOCATION (City, town, or county) Caldwell, (State) Idaho

DATE REC'D BY LOCAL REG. Dec 23-1969

REGISTRAR'S SIGNATURE Myrtle H. Gardner

25. EMBALMER Burton E. Walker

LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5952
Local Reg. No. 28
Reg. Dist. No. 310

BIRTH NO.

RECEIVED
DEC 30 1969
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley County Hospital 162

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
d. STREET ADDRESS (If rural, give location): Box 289

3. NAME OF DECEASED (Type or Print): a. (First) EVA b. (Middle) FLORA c. (Last) HOFFMAN

4. DATE OF DEATH (Month) (Day) (Year): December 16, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 29, 1910

9. AGE (In years last birthday): 59
IF UNDER 1 YR. Months | Days
IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Center, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Eisenbeiss
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Emma
BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 519-30-7374

17. INFORMANT'S OWN SIGNATURE: [signature], ADDRESS: McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1929

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) METASTATIC CANCER — INTERVAL BETWEEN ONSET AND DEATH: 2 MTHS

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) MALIGNANT MENINGIOMA — UNK.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DIABETES — 12 YRS

19a. DATE OF OPERATION: OCT 69

19b. MAJOR FINDINGS OF OPERATION: MENINGIOMA

20. AUTOPSY? Yes ☐ No ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): CASCADE VALLEY IDA

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DEC 10, 19__, *to* DEC 16, 19 69, *that I last saw the deceased alive on* DEC 16, 19 69, *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: John J. Moser (Degree or title) MD 376

23b. ADDRESS: CASCADE IDAHO

23c. DATE SIGNED: 12/22/69

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec 20, 1969

24c. NAME OF CEMETERY OR CREMATORY: McCall Cemetery

24d. LOCATION (City, town, or county) (State): McCall Idaho

DATE REC'D BY LOCAL REG.: Dec-24-1969

REGISTRAR'S SIGNATURE: Myrtle M. Gardner

25. EMBALMER: Burton C Walker

LICENSE NO.: E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5953
Local Reg. No. 7
Reg. Dist. No. 310

BIRTH NO.

RECEIVED DEC 30 1969 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (In this place) 3½ weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location) Box 629

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES
b. (Middle) EDWIN
c. (Last) HERRICK

4. DATE OF DEATH (Month) (Day) (Year) December 17, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH October 17, 1893

9. AGE (In years last birthday) 76
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher, retired 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Lake Geneva, Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Clarence A. Herrick
BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Eliza Varley
BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-09-7628-A

17. INFORMANT'S OWN SIGNATURE Mrs Lenen Herrick
ADDRESS McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

185X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) malnutrition — 6 months
DUE TO (c) Carcinoma of Prostate — 6 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1969, *to* Dec, 1969, *that I last saw the deceased alive on* Dec 17, 1969, *and that death occurred at* 9:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 391 Donald S. Roker M.D.

23b. ADDRESS McCall, Idaho

23c. DATE SIGNED 12-22-69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3

24b. DATE Dec 20, 1969

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial

24d. LOCATION (City, town, or county) Twin Falls, (State) Idaho

DATE REC'D BY LOCAL REG. Dec 23-1969

REGISTRAR'S SIGNATURE Myrtle M Gardner

25. EMBALMER Burton C Walker

LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

RECEIVED JAN 7 1970 Bureau of Vital Statistics

State File No. 5954
Local Reg. No. 27
Reg. Dist. No. 3/8

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) rural Cascade, south
LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hiway 55-milepost 144.7 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location) rural

3. NAME OF DECEASED (Type or Print) a. (First) MERLE b. (Middle) E. c. (Last) CLARK

4. DATE OF DEATH (Month) (Day) (Year) December 23, 1969

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH April 9, 1927

9. AGE (In years last birthday) 42
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logging Contractor 17

10b. KIND OF BUSINESS OR INDUSTRY Independent

11. BIRTHPLACE (State or foreign country) Elkhart, Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Floyd McKeen Clark
BIRTHPLACE Lyons, Nebraska

14. MOTHER'S MAIDEN NAME Lillian Godfrey
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW 2 4

16. SOCIAL SECURITY NO. 519-20-7311

17. INFORMANT'S OWN SIGNATURE Ingrid E. Clark
ADDRESS McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) asphyxiation
INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) drowning
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Highway 55 06

21c. (CITY, TOWN, OR TOWNSHIP) 3430 (COUNTY) Valley (STATE) Idaho
rural Cascade

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 23, '69 aprox 1 a.m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR? vehicle plunged into river

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at __ m., from the causes and on the date stated above.*

23a. SIGNATURE Burton E Walker 583 4 (Degree or title) Coroner

23b. ADDRESS McCall, Idaho

23c. DATE SIGNED 12/26/69

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE December 26, '69

24c. NAME OF CEMETERY OR CREMATORY McCall Cemetery

24d. LOCATION (City, town, or county) McCall, (State) Idaho

DATE REC'D BY LOCAL REG. Dec 27-69

REGISTRAR'S SIGNATURE Myrtle A Gardner

25. EMBALMER Burton E Walker

LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 7 1970

MAR 5 1975

JUN 5 1979

JUN 18 1980

NOV. - 4 1992

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5955
Local Reg. No. 33
Reg. Dist. No. 320

RECEIVED DEC 16 1969 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (In Statistics)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 440
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): Martha
b. (Middle): Ellen
c. (Last): Allison

4. DATE OF DEATH (Month) (Day) (Year): 12 2 1969

5. SEX: female
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 3/25/1878
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Salubria Valley, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harrison Abernathy — BIRTHPLACE: -----
14. MOTHER'S MAIDEN NAME: Elizabeth South — BIRTHPLACE: ------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Lois A. Danielson — ADDRESS: Cambridge, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1541 Carcinoma lectum — metastases — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Sen. arteriosclerosis — yes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/31, 1969, *to* 12/2, 1969 *that I last saw the deceased alive on* 12/1, 1969, *and that death occurred at* 5 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. Kirkwheeler MD 407
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 12/2/69

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 12/5/69
24c. NAME OF CEMETERY OR CREMATORY: Salubria Cemetery
24d. LOCATION (City, town, or county) (State): Cambridge Washington Ida.

DATE REC'D BY LOCAL REG.: 12-2-69
REGISTRAR'S SIGNATURE: R. Dale Thomason
25. EMBALMER: R. Dale Thomason
LICENSE NO.: E 388

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

OCT 1 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 25 2003

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5956
Local Reg. No. 34
Reg. Dist. No. 320

RECEIVED
DEC 29 1969

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington 440
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (In this place): Visit
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 1 OOC

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Washington 440
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Cheryl	Ann	Lawrence	12	11	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	never married	5/30/1960	9				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student 03	-----	San Jose, California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ronald A. Lawrence	San Jose, Calif.	Josephine DeMaria	San Jose, Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			Lon Lawrence	Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congestive Heart Failure

DUE TO (c) Muscular Dystrophy (Pseudohypertrophic Myopathy)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-24-, 1969, *to* 12-11-, 1969, *that I last saw the deceased alive on* 12-11-, 1969, *and that death occurred at* 6:35 *A.M., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
344 M.A. McGrath M.D.	Weiser, Idaho	12/11/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	12/13/69	Hillcrest Cemetery	Weiser Washington Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-11-69	L. Dan Thomson	Marshall S. Dickerson Jr.	E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 30 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5957
Local Reg. No. 35
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 44 Washington — DEC 29 1969 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL) Weiser — LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Adams 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitvale
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
FRANCIS	STERLING	MCGINLEY	Dec.	13	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 19, 1893	76	5	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retailer 22	Merchant	Ogallala, Nebraska	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James McGinley	----	----	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	318-28-7220	Mrs Henry Kamerdula	Fruitvale

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) C.V.A.

DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-28- , 19 69 , *to* 12-13- , 19 69 , *that I last saw the deceased alive on* 12-13- , 19 69 , *and that death occurred at* 9:40 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Professional title)	23b. ADDRESS	23c. DATE SIGNED
344 W.S. McGrath MD	Weiser, Idaho	Dec.13,1969

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec.16,1969	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec.13,1969	L. Dale Thomsen	L. Dale Thomsen	E-388

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DEC 3 0 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5958
Local Reg. No. 36
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
DEC 29 1969
Bureau of Vital Statistics

1. PLACE OF DEATH — a. COUNTY: Washington — b. CITY OR TOWN: Weiser — c. LENGTH OF STAY (in this place): — d. FULL NAME OF HOSPITAL OR INSTITUTION: Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Washington — c. CITY OR TOWN: Weiser — d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print) — a. (First): Vica — b. (Middle): — c. (Last): Cahill

4. DATE OF DEATH — (Month): Dec. — (Day): 19 — (Year): 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 22, 1894

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months: 7 — Days: 27 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Patoka, Illinois

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: James Hawkins — BIRTHPLACE: Patoka, Illinois

14. MOTHER'S MAIDEN NAME: Elizabeth --- — BIRTHPLACE: Patoka, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: x Lewis Cahill — ADDRESS: Weiser, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A. — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertension

DUE TO (c) Diabetes

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-13-, 1969, *to* 12-19-, 1969, *that I last saw the deceased alive on* 12-19-, 1969, *and that death occurred at* 10:10 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. McGlothlin M.D. — 23b. ADDRESS: Weiser — 23c. DATE SIGNED: Dec.19,1969

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: Dec.23,1969 — 24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — 24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: Dec.19,1969 — REGISTRAR'S SIGNATURE: T. Dave Thomason — 25. EMBALMER: T. Dave Thomason — LICENSE NO.: E-388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5959
Local Reg. No. 37
Reg. Dist. No. 320

RECEIVED JAN 9 1970 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 44 Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1418 N. 19th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Viola	Ella	Vandever	12	23	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	married	3/27/1910	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Webb City, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE William Marshall --
14. MOTHER'S MAIDEN NAME BIRTHPLACE Beulah --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE *Frank L Vandever ADDRESS Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis 4100
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 12-11-69, *to* 12-23-69, *that I last saw the deceased alive on* 12-23-69, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE AND DEGREE OR TITLE 344 M.D. McGeehan M.D.
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED 12/24/69

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 12/27/69
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser Washington (State) Idaho

DATE REC'D BY LOCAL REG. 12-29-69
REGISTRAR'S SIGNATURE T. Dale Thomson
25. EMBALMER T. Dale Thomson
LICENSE NO. E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: APR 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5960
Local Reg. No. 38
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
JAN 13 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Haven Manor 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Washington 440
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cambridge
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Larry	B.	Marti	12	30	1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	never married	3/4/1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
factory worker 06	shoes	Beloit, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
H.L. Marti	-----	Fannie Babler	-----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	391 07 5043	Daisy Marti	Cambridge

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4100 Coronary Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive Heart Disease

DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-16- *, 19*66*, to* 12-30 *, 19*69*, that I last saw the deceased alive on* 12-30- *, 19*69*, and that death occurred at* 6:40 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
344 M.D. McGrath MD	Weiser, Idaho	12/30/69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	1/3/1970	Cambridge Cemetery	Cambridge Wash. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-30-69	T. Lee Thomson	T. Lee Thomson	E 388

FIRM NAME Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5961
Local Reg. No. 964
Reg. Dist. No. 570

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

JAN 27 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise,
c. LENGTH OF STAY (in this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 315 Diamond

3. NAME OF DECEASED (Type or Print)
a. (First): Matio
b. (Middle): M.
c. (Last): Cerda

4. DATE OF DEATH (Month) (Day) (Year): December 8, 1969

5. SEX: Male
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 28, 1945
9. AGE (In years last birthday): 24 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Mexico
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dionicio Cerda — BIRTHPLACE: Mexico
14. MOTHER'S MAIDEN NAME: Leonor Reyez — BIRTHPLACE: Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 58 0789
17. INFORMANT'S OWN SIGNATURE: X Olga I Cerda — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8199

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Head Trauma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ~~ACCIDENT~~ SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: Car Accident

22. *I hereby certify that I attended the deceased from* 12-8, 1969, *to* 12-8, 1969, *that I last saw the deceased alive on* 12-8, 1969, *and that death occurred at* 1:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 1-20-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12=11=69
24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Jan. 26, 1970
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Glen G. Siren — LICENSE NO. 498

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shepherd Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 28 1970

JAN 29 1971

JAN 9 1990

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5962
Local Reg. No. 965
Reg. Dist. No. 370

BIRTH NO. 69-12952

RECEIVED FEB 3 1970 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Lukes	d. STREET ADDRESS (If rural, give location): Runway Drive

3. NAME OF DECEASED (Type or Print) a. (First): Brian	b. (Middle): Walter	c. (Last): Bonney	4. DATE OF DEATH (Month) (Day) (Year): Dec. 15, 1969
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: Dec. 15, 1969
9. AGE (In years last birthday):	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min: 1 / 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Boise, Idaho	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Gary Bonney	BIRTHPLACE: Idaho	14. MOTHER'S MAIDEN NAME: Linda L. Wolt	BIRTHPLACE: IdAHO
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):	16. SOCIAL SECURITY NO.: None	17. INFORMANT'S OWN SIGNATURE: X Gary W. Bonney	ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

7589

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Mermaid deformity

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____ 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 9:40 P m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): M.D.	23b. ADDRESS: Boise	23c. DATE SIGNED: 1/26/70	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12-20-69	24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery	24d. LOCATION (City, town, or county) (State): Meridian, Idaho
DATE REC'D BY LOCAL REG.: Jan. 30, 1970	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Jack W. Green	LICENSE NO.: 528

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

69-9841
BIRTH NO.

RECEIVED
FEB 3 1970
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5963
Local Reg. No. 49
Reg. Dist. No. 510

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1002 Samuel Avenue

3. NAME OF DECEASED (Type or Print): a. (First) TONYA; b. (Middle) LOU; c. (Last) YOUNG

4. DATE OF DEATH: (Month) October (Day) 4 (Year) 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: October 4, 1969

9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours 0 2, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): *****

10b. KIND OF BUSINESS OR INDUSTRY: *****

11. BIRTHPLACE (State or foreign country): Pocatello Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Thomas Young — BIRTHPLACE: Omaha, Nebraska

14. MOTHER'S MAIDEN NAME: Jacquelin Gardiol — BIRTHPLACE: Salmon, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: *****

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain tumor — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Both 19__, *to* Sept 19__, *that I last saw the deceased alive on* Oct, 19 69, *and that death occurred at* 1255 p m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) M D

23b. ADDRESS: 527 S. 12th

23c. DATE SIGNED: 1/26/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 7, 1969

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: FEB 2 1970

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: [signature]

LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5964
Local Reg. No. #30
Reg. Dist. No.

BIRTH NO.

RECEIVED FEB 17 1970 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Bonner

b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Sandpoint

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bonner

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Careywood

d. STREET ADDRESS (If rural, give location): Careywood, Idaho

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	GEORGE	B.	WALLACE	Oct. 16, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	9/14/1899	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dairy Farmer	Dairy Farming	Mo.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joshua Wallace	Tenn.	Alice Myers	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I	519-10-4576	Marie Wallace	Careywood, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 409 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Residence	Careywood Bonner Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	deceased piling wood, had coronary and died

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dan D Wilson Coroner	Sandpoint Idaho	2-13-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/21/69	Restlawn Mem. Park	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
2/16/70	Hale Peterson	L G Moon Jr.	E-405

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. APR 13 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 21 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5965
Local Reg. No. 1
Reg. Dist. No.

BIRTH NO.

RECEIVED FEB 10 1970 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bonner

b. CITY OR TOWN (If outside corporate limits, write RURAL or township): Sandpoint

c. LENGTH OF STAY (in this place): 5 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bonner

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clark Fork

d. STREET ADDRESS (If rural, give location): Box 264

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Margaret	Christine	Powell	November 7, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Oct. 18, 1900	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retail Clerk	Grocery	Clark Fork, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Schlicht	Germany	Christine M. Thompsen	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 24 1753	Mrs Robert C. Hays	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Coronary Occlusion	5 min
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Cirrhosis of the Liver	3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-2, 1969, *to* 11-7, 1969, *that I last saw the deceased alive on* 11-6, 1969, *and that death occurred at* 6:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John L. Smith MD	Sandpoint, Idaho	11-15-69

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL	Nov 10, 1969		Radnor, Ohio

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
2/9/70	Hale Sederwall	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

THIS CERTIFICATE WAS RECEIVED AT MOON FUNERAL HOME

FROM JOHN W. SMITH, M.D., ON FEBRUARY 2, 1970.

RECEIVED
FEB 10 1970
Bureau of Vital Statistics

MOON FUNERAL SERVICE

FEB 10 1970

JUL 20 1972

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5966
Local Reg. No. #8
Reg. Dist. No.

BIRTH NO.

RECEIVED JAN 30 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (If not in this place): 2 yrs 8 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 723 N. Florence

3. NAME OF DECEASED (Type or Print)
a. (First): Helen
b. (Middle): Louise
c. (Last): Ebert

4. DATE OF DEATH (Month) (Day) (Year): December 21, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 7, 1882
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Steven Otis — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Alice Barnes — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 518 60 4871
17. INFORMANT'S OWN SIGNATURE: Louis Ebert — ADDRESS: Sandpoint, Id.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4270

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Pneumonia — Congestive — Chronic
DUE TO (c): Heart Failure — CHF

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 10, 1958, *to* Dec 21, 1969, *that I last saw the deceased alive on* Dec 18, 1969, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 1/23/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 23, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pack River Cemetery
24d. LOCATION (City, town, or county) (State): Bonner County Idaho

DATE REC'D BY LOCAL REG.: 1/29/70
REGISTRAR'S SIGNATURE: Dale Pedersen
25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5967
Local Reg. No. #6
Reg. Dist. No.

BIRTH NO.

RECEIVED JAN 30 1970 Bureau of Vital

1. PLACE OF DEATH a. COUNTY: Bonner	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint c. LENGTH OF STAY (In this place): 4 mos	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Old Town
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First): Chester	b. (Middle): Devils	c. (Last): Scott	4. DATE OF DEATH (Month) (Day) (Year): Dec 22 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: June 13 1888	9. AGE (In years last birthday): 81 IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: Lumber	11. BIRTHPLACE (State or foreign country): Wisconsin	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas W. Scott	BIRTHPLACE: Pennsylvania	14. MOTHER'S MAIDEN NAME: Ada Emerson	BIRTHPLACE: Unobtainable	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 518 05 4867	17. INFORMANT'S OWN SIGNATURE: Alan D. Scott	ADDRESS: Newport Wa.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

486 X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	PNEUMONIA —	2-3 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	CACHEXIA - malnutrition	2 months
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 10, 1964, *to* Dec 22, 1969, *that I last saw the deceased alive on* Dec 22, 1969, *and that death occurred at* 12 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title)	23b. ADDRESS: Sandpoint Idaho	23c. DATE SIGNED: 1/23/70
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal	24b. DATE: 12/22/69	24c. NAME OF CEMETERY OR CREMATORY: Sherman Funeral Home
24d. LOCATION (City, town, or county) (State): Newport, Wa. 99156		
DATE REC'D BY LOCAL REG.: 1/28/70	REGISTRAR'S SIGNATURE: [signature]	25. EMBALMER: R. D. Sherman
LICENSE NO.: QL749		

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Sherman Funeral Home, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

MAR 2 1 2005

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 30 1970 Bureau of Vital Sta.

Certificate of Death

STATE OF IDAHO

State File No. 5968
Local Reg. No. #11
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sagle
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Ora b. (Middle) B. c. (Last) Phillips

4. DATE OF DEATH (Month) (Day) (Year): December 29, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: August 8, 1899

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales woman

10b. KIND OF BUSINESS OR INDUSTRY: Real Estate

11. BIRTHPLACE (State or foreign country): Washington

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George B. Parks
BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Rebecca Whitely
BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519 60 9444

17. INFORMANT'S OWN SIGNATURE: Harry B Phillips
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Myocardial infarction — Years
DUE TO (c): Coronary artery disease — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Lupus Erythematosus — Years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 15, 1952, *to* Dec 29, 1969, *that I last saw the deceased alive on* Dec 16, 1969, *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harry W Benson
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 1/23/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Jan. 6, 1970
24c. NAME OF CEMETERY OR CREMATORY: Clarkston Memorial Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 1/29/70
REGISTRAR'S SIGNATURE: Hale Tedrow

25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Service

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5969
Local Reg. No. 60
Reg. Dist. No. 360

RECEIVED FEB 3 1970 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN: Nampa
LENGTH OF STAY (in this place): 37 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: Idaho State School & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN: Caldwell
d. STREET ADDRESS: Route 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Robert	Buell	Greenfield	11-27-69

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	10-9-24	45				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel F. Greenfield	Missouri	Katherine Carrier	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Wilma Keiser	Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Myocardial Infarction	30 min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute Coronary occlusion	30 min
DUE TO (c)	Coronary atherosclerosis	10 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Downs Syndrome + Patent Foramen ovale	45 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 11-17, 1969, *to* 11-27, 1969, *that I last saw the deceased alive on* 11-27, 1969, *and that death occurred at* 7:50 Am., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Nampa Idaho	27 Jan 1970

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-1-69	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Feb. 2, 1970	Mrs Martina Walmsley	[signature]	473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5970
Local Reg. No. 46
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 27 1970 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 5

3. NAME OF DECEASED (Type or Print): a. (First) Robert; b. (Middle) John; c. (Last) Mann

4. DATE OF DEATH (Month) (Day) (Year): Dec. 20, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 27, 1910

9. AGE (In years last birthday): 59
IF UNDER 1 YR. Months / Days:
IF UNDER 24 HRS. Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Amarillo, Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James E. Mann
BIRTHPLACE: Texas

14. MOTHER'S MAIDEN NAME: Pearl Byers
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): War II

16. SOCIAL SECURITY NO.: 553-07-2103

17. INFORMANT'S OWN SIGNATURE: X Helen Marie Mann
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* December 20, 1969 *to* December 20, 19 69 *that I last saw the deceased alive on* December 20, 1969 *and that death occurred at* 4:30p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Charles E. Reed M.D. (Degree or title): M.D.

23b. ADDRESS: 222 E. Elm, Caldwell, Idaho

23c. DATE SIGNED: 1/16/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: Dec. 23, 1969

24c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

24d. LOCATION (City, town, or county) (State): Bakersfield, Calif.

DATE REC'D BY LOCAL REG.: Jan. 26, 1970

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Rodney W. Dakan

LICENSE NO.: E-508

FIRM NAME: Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service FORM DH-63021

JAN 27 1970
JAN 30 1970
FEB 4 1970
DEC 3 1973
JUL 23 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5971
Local Reg. No. 43
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 27 1970 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 9½ years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 813 12th North

3. NAME OF DECEASED (Type or Print): a. (First) Terrence; b. (Middle) Richard; c. (Last) Healy

4. DATE OF DEATH (Month) (Day) (Year): December 22, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: 4-23-47

9. AGE (In years last birthday): 22 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Dayton, Washington

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leo B. Healy — BIRTHPLACE: Montana

14. MOTHER'S MAIDEN NAME: Margie Wolfe — BIRTHPLACE: Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Wilma Keyser — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4868

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Mental Retardation (severe)
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-22, 19 69, *to* 12-22-, 19 69, *that I last saw the deceased alive on* 12-22, 19 69, *and that death occurred at* 1:20 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eugene E. Brown M.D.
23b. ADDRESS: 619 So. Canyon Nampa
23c. DATE SIGNED: 1/21/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Dec. 24, 1969
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county): Jerome (State): Idaho

DATE REC'D BY LOCAL REG.: Jan 26, 1970
REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley
25. EMBALMER: [signature]
LICENSE NO.: E-496
FIRM NAME: Aisp Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5972
Local Reg. No. 44
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 27 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 48 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Samuels
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print): a. (First) Pearl; b. (Middle); c. (Last) Barfuss

4. DATE OF DEATH (Month) (Day) (Year): December 23, 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: 9-7-11

9. AGE (In years last birthday): 58
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bancroft, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gotfred Barfuss — BIRTHPLACE: Switzerland

14. MOTHER'S MAIDEN NAME: Anna Wyttenbach — BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Wilma Keyser — ADDRESS: Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia Rt. - Recurrent. — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severe Mental Retardation c Seizures — 50 yrs

DUE TO (c) Hypostatic - Bed pt. — 50 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Ext. left atrial hipoma —

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-12-, 1969, *to* 12-23, 1969, *that I last saw the deceased alive on* 12-22, 1969, *and that death occurred at* 8:45 Am., *from the causes and on the date stated above.*

23a. SIGNATURE: C O'Riordan — (Degree or title): MD

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 1-21-1970

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-30-69

24c. NAME OF CEMETERY OR CREMATORY: Kohlerdown Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Jan. 26, 1970

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: M C Shepherd

LICENSE NO.: 473

FIRM NAME: Shepherd Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death
STATE OF IDAHO

State File No. 5974
Local Reg. No. 98
Reg. Dist. No. 142

BIRTH NO.

RECEIVED
FEB 3 1970
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY Shoshone	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Idaho b. COUNTY Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg c. LENGTH OF STAY (In this place) DOA	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kingston
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) FORREST	b. (Middle) RAY	c. (Last) ROSSON	4. DATE OF DEATH (Month) (Day) (Year) 12-20-1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-3-1919	9. AGE (In years last birthday) 50 — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	10b. KIND OF BUSINESS OR INDUSTRY City Maintenance	11. BIRTHPLACE (State or foreign country) Liberty Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin L. Rosson	BIRTHPLACE Unobt.	14. MOTHER'S MAIDEN NAME Ella Arnold	BIRTHPLACE Unobt.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 493-14-6375	17. INFORMANT'S OWN SIGNATURE X Mrs. Dorris Rosson,	ADDRESS Kingston Id.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable Acute Myocardial Infarction.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Dead on Arrival at Hospital.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) Kellogg (COUNTY) Shoshone (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE R K Parker (Degree or title)	23b. ADDRESS Kellogg Idaho	23c. DATE SIGNED 1-27-70	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-24-1969	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) Kellogg (State) Idaho
DATE REC'D BY LOCAL REG. 1/28/70	REGISTRAR'S SIGNATURE [signature]	25. EMBALMER Russell D. Mikel	LICENSE NO. E-520

FIRM NAME Cornell's Maisel Funeral Ch.

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

FEB 4 1970

MAR 1 1 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5975
Local Reg. No. #22
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED MAR 2 1970 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): Fay
c. (Last): Campbell

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 16, 1898
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Byron A. Campbell — BIRTHPLACE: Michigan
14. MOTHER'S MAIDEN NAME: Elsie Fay — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 16 3408
17. INFORMANT'S OWN SIGNATURE: x Donald P Campbell — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8199 Thrombosis Middle Cerebral artery related — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Severe Brain Concussion — 72 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): U.S. Highway
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Bonner 090 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-14-69 3:00 m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Auto accident

22. *I hereby certify that I attended the deceased from* 9-14, 1969, *to* 9-18, 1969, *that I last saw the deceased alive on* 9-18, 1969 *and that death occurred at* 10:10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Fred E. Marienau MD (Degree or title) 327
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 2-26-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 23, 1969
24c. NAME OF CEMETERY OR CREMATORY: Pack River Cemetery
24d. LOCATION (City, town, or county) (State): Bonner County Idaho

DATE REC'D BY LOCAL REG.: 2/27/70
REGISTRAR'S SIGNATURE: Dale Anderson
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 3 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 16 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5976
Local Reg. No. 162
Reg. Dist. No. 360

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

APR 7 1970
Bureau of Vital Statistics
Illinois

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township or other place): Caldwell
c. LENGTH OF STAY (If in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise River Euvalde at No.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 411 Chicago

3. NAME OF DECEASED (Type or Print)
a. (First): Elaine
b. (Middle): L.
c. (Last): Welch

4. DATE OF DEATH (Month) (Day) (Year): Dec. 24, 1969

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Sept. 29, 1943
9. AGE (In years last birthday): 26 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Self.
11. BIRTHPLACE (State or foreign country): Coeur D Alene, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Earl Osborn — BIRTHPLACE: Wisc.
14. MOTHER'S MAIDEN NAME: Erma Tryon — BIRTHPLACE: Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 444-42-5362
17. INFORMANT'S OWN SIGNATURE: Erma Pond — ADDRESS: California
Erma Pond 1330 West Walnut Lodi

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8169

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning, Accidental

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto Accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Boise River
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Caldwell Canyon Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 24 1969 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Car plunged into river and overturned

22. *I hereby certify that I attended the deceased from* History. Body not found until *19___, to ___, 19___, that I last saw the deceased* ~~XX~~ 3-27-70 *, 19___, and that death occurred at ___ m., from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesche — 560-4 (Degree or title): M. D. Coroner
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 3-31-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
24b. DATE: 4-1-70
24c. NAME OF CEMETERY OR CREMATORY: Cherokee Memorial Park
24d. LOCATION (City, town, or county) (State): Lodi, California

DATE REC'D BY LOCAL REG.: April 3, 1970
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 8 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5977
Local Reg. No. 47
Reg. Dist. No. 450

BIRTH NO.

RECEIVED JUL 2 - 1970

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF [illegible] in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 100 East 125 South

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) Lewis c. (Last) Gummerson

4. DATE OF DEATH (Month) (Day) (Year): Dec. 21, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 15, 1896

9. AGE (In years last birthday): 73
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): unknown Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Mathew Gummerson BIRTHPLACE: Shell City, Mo

14. MOTHER'S MAIDEN NAME: Sararh Reed BIRTHPLACE: unknown, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-44-0314

17. INFORMANT'S OWN SIGNATURE: Mary Gummerson ADDRESS: Rupert, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4109

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 21, 1969 *to* December 21, 1969 *, that I last saw the deceased alive on* Dec. 21 *, 19* 69 *, and that death occurred at* 3:- A. *m., from the causes and on the date stated above.*

23a. SIGNATURE C. F. Dalley M.D. (Degree or title) 127-1

23b. ADDRESS 902 D Street Rupert, Idaho

23c. DATE SIGNED: 6-29-70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-24-69

24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery

24d. LOCATION (City, town, or county): Rupert (State): Idaho

DATE REC'D BY LOCAL REG.: 6-30-70

REGISTRAR'S SIGNATURE: Mary Ellen Carlson

25. EMBALMER: Charles L Persons

LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

State File No. 5978
Local Reg. No. 45
Reg. Dist. No. 45 D

BIRTH NO.

RECEIVED JUL 2 - 1970 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (In this place): 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Frank; b. (Middle) Tyler; c. (Last) Davis

4. DATE OF DEATH (Month) (Day) (Year): Dec. 30, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	Mar. 7, 1896	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unable to work		Villisca, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Oscar Davis	Phillipsburg, Kansas	Mattie Ming	Villisca, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	--	Mae Hoff	Rupert, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a)	550X General debilities of advanced years	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Large inguinal hernea	meny years
DUE TO (c)	Severe chronic rheumatoid arthritis.	many years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1946, *to* December 30, 1969, *that I last saw the deceased alive on* December 28, 1969, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. F. Dalley M.D. 127-1	703 F Street, Rupert, Idaho	6-29-70

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	12-31-69	Rupert Cemetery	Rupert	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-30-70	Mary Ellen Carlson.	Charles H Persons	E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service FORM OPH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 17 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

1969 5979
State File No.
Local Reg. No. 200
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JUL 27 1973 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cataldo
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Near Coeur d'Alene River, I-90

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 435 Park Drive

3. NAME OF DECEASED (Type or Print) a. (First): John b. (Middle): Forrest c. (Last): Conners

4. DATE OF DEATH (Month) (Day) (Year): June 13, 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unknown

8. DATE OF BIRTH: 5/1/1898

9. AGE (In years last birthday): 71
IF UNDER 1 YR. Months: 1 Days: 12
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): St. John, New Brunswick Canada

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Unknown
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: Kootenai County Sheriff's Office
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7969

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Cause Unknown.
INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kootenai, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 6 - 13 - '69 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Disappeared 6-13-'69

22. I hereby certify that I attended the deceased from Did not _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): William T. Wood, M.D. Coroner
23b. ADDRESS: Coeur d'alene Idaho
23c. DATE SIGNED: 7-24-73

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 7/20/1973
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Funeral Home,
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: July 25, 1973
REGISTRAR'S SIGNATURE: Lorraine M. Brush
25. EMBALMER: Gilbert Yates
LICENSE NO.: M-365

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

1969 State File No. 5980
Local Reg. No. 46-73
Reg. Dist. No. 100

BIRTH NO.

RECEIVED JAN 3 1974 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bottleneck Peak, Selkirk Mts.

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
a. STATE: Idaho
b. COUNTY: Boundary
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): 304 Ash Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ERIK	JOHN	VeNARD	August 19, 1969

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Never Married	Oct. 31, 1949	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Sawmill	Milwaukee, Wisconsin	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dan L. VeNard	Fulton County, Illinois	Laura W. Kaakinen	Trimountain, Mich.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	———	518-56-8073	Dan L. VeNard	Bonners Ferry, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

988X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): UNDETERMINED (See Attached)

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* LEGAL DECLARATION OF DEATH, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Callahan C. M. CALLAHAN	583-4 Coroner	Bonners Ferry, Idaho	12/27/73

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	12/29/73	Grandview Cemetery	Bonners Ferry	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 28, 1973	Wyla Stone	Charles V. Malone	M-453

FIRM NAME: MALONE FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS ~~by Physician~~ Body not embalmed. Sketal remains only interred.

Memorial Service For Erik VeNard Scheduled Wednesday

A memorial service for Erik John VeNard, whose remains were found on the Bottleneck Peak ridge of the Selkirk Mountains on Sept. 1, 1973, and who had been missing since August 19, 1969, will be held for the family and friends at the Trinity Lutheran Church on December 26 at 8:00 p.m. with Pastor Hippe officiating, the VeNard family announced.

Erik was born on October 31, 1949, in Milwaukee, Wis., the son of Dan L. and Laura Kaakinen VeNard.

He attended school in Milwaukee until 1959, when his family moved to Bonners Ferry. He established himself as a student in Bonners Ferry High School, which he attended three years, moving for his senior year to Seneca High School in Louisville, Ky., where he resided with his sister.

At Seneca he became known for his ability in writing, showing promise in both [illegible] student, he did not find college atmosphere to his liking and moved back to Bonners Ferry, where he worked at several occupations until his disappearance.

Truth, beauty in the world, and nature were Erik's passions. An untimely end in one so gifted is saddening; however, a more appropriate place than the mountains he loved could not be found. There he found peace from the world which fascinated and repelled him.

Family members include the parents and four brothers and a sister: William of San Francisco, Calif.; Bob of Moscow; Paul at home; Mary Clara Stevenson of St. Louis, Mo.; and a half-brother, Dan II of Paradise Valley.

The Malone Funeral Home is in charge of arrangements. Memorials in lieu of flowers may be made to the Trinity Lutheran church, or to the Idaho chapter of the Mental Health Association for the care of emotionally disturbed children.

named estate has filed his final account and petition for settlement and distribution of the above named estate, a copy of which is on file with the First Judicial District of the State of Idaho, in and for the County of Boundary, Magistrate's Division, Boundary County Courthouse, Bonners Ferry, Idano, and which can be examined there by any interested person.

Hearing upon said account and petition will be held on Tuesday, January 8, 1974, at 9:30 o'clock a.m., in the above named Court, at which time objection to said account and petition will be heard.

DATED this 14th day of December, 1973.

/s/ Peter B. Wilson
Personal Representative

First pub. Dec. 20, 1973
Final Pub. Jan. 3, 1974-w&w

NOTICE OF CLAIM TO A WATER RIGHT
NO. 98-4034

AFFIDAVIT

STATE OF IDAHO)
) ss.
County of Boundary)

Dan L. VeNard and Laura W. VeNard, Husband and Wife, being first duly sworn on oath, depose and each for himself says:

That their son, Erik John VeNard, born on October 31, 1949, Social Security No. 518-56-8073, went camping in the Bottleneck Peak area of the Selkirk Mountains, Boundary County, Idaho, on August 19, 1969. That since that time he has never returned or been heard from. That in a search of the area on SEPTEMBER 1ST, 1973, the following items were found:

a single shot 22 rifle with scope
a portable radio
binoculars
a shirt
sun glass rims
a duffel bag
a sleeping bag
a hat

That affiants and parents of Erik John VeNard can positively, and have, identified the above items as belonging to their missing son.

That based on the absence of their son, and the property which has been found and identified, affiants state that they are certain that their son, Erik John VeNard, is dead.

Dan L. VeNard
Dan L. VeNard

Laura W. VeNard
Laura W. VeNard

SUBSCRIBED and SWORN to before me this 28TH day of DECEMBER, 1973.

Notary Public for Idaho
Residing at Bonners Ferry
Com. Exp.: 12-20-76